BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation and Petition to Revoke Probation Against: Scott Eisenkop, M.D. Physician's and Surgeon's Certificate No. G 41053 Respondent.	Case No.: 800-2019-062815

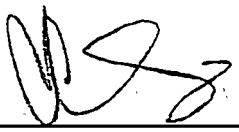
DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on January 13, 2022.

IT IS SO ORDERED: December 14, 2021.

MEDICAL BOARD OF CALIFORNIA



Laurie Rose Lubiano, J.D., Chair
Panel A

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
VLADIMIR SHALKEVICH
Deputy Attorney General
State Bar No. 173955
California Department of Justice
300 South Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6538
Facsimile: (916) 731-2117
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation and Petition to Revoke Probation Against: **SCOTT EISENKOP, M.D.** **29525 Canwood Street, Suite 205** **Agoura Hills, CA 91301** **Physician's and Surgeon's Certificate No. G 41053,** Respondent.	Case No. 800-2019-062815 OAH No. 2021030950 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Vladimir Shalkevich, Deputy Attorney General.

2. Respondent Scott Eisenkop, M.D. (Respondent) is represented in this proceeding by attorney Benjamin J. Fenton, whose address is: 1990 South Bundy Drive, Suite 777, Los Angeles, CA 90025.

3. On or about October 15, 1979, the Board issued Physician's and Surgeon's Certificate No. G 41053 to Scott Eisenkop, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect, subject to probationary terms and conditions, at all times relevant to the charges brought in Accusation and Petition to Revoke Probation No. 800-2019-062815, and will expire on March 31, 2023, unless renewed.

JURISDICTION

4. Accusation and Petition to Revoke Probation No. 800-2019-062815 was filed before the Board, and is currently pending against Respondent. The Accusation and Petition to Revoke Probation and all other statutorily required documents were properly served on Respondent on December 10, 2020. Respondent timely filed his Notice of Defense contesting the Accusation and Petition to Revoke Probation.

5. A copy of Accusation and Petition to Revoke Probation No. 800-2019-062815 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation and Petition to Revoke Probation No. 800-2019-062815. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation and Petition to Revoke Probation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

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CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation and Petition to Revoke Probation No. 800-2019-062815, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent does not contest that, at an administrative hearing, Complainant could establish a prima facie case or a factual basis with respect to the charges and allegations in Accusation and Petition to Revoke Probation No. 800-2019-062815, a true and correct copy of which is attached hereto as Exhibit A, and is incorporated herein, and that he has thereby subjected his Physician's and Surgeon's Certificate, No. G 41053 to disciplinary action.

11. Respondent agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in Accusation and Petition to Revoke Probation No. 800-2019-062815 shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

12. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

13. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

14. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation and Petition to Revoke Probation No. 800-2019-062815 shall be deemed true, correct and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

15. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

16. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final, and exclusive embodiment of the agreements of the parties in the above-listed matter.

17. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or opportunity to be heard by Respondent, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 41053 issued to Respondent Scott Eisenkop, M.D. is revoked. However, the revocation is stayed and Respondent's probation, previously imposed in the Board's Decision and Order in Case No. 17-2012-224090, including all of the terms and conditions therein, is extended for a period of seven (7) years, which are to run consecutive to the current probationary period. The Board's Decision and Order in Case No. 17-2012-224090 is incorporated herein by reference. In addition to the terms and conditions of probation ordered in the Board's Decision and Order in Case No. 17-2012-224090, the following terms and conditions are hereby added, and shall take effect immediately:

1. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully

complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If Respondent did not successfully complete the clinical competence assessment program, Respondent shall not resume the practice of medicine until a

final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

Failure to successfully complete the program not later than six (6) months after Respondent's initial enrollment, unless the Board or its designee agrees in writing to an extension of that time, is a violation of probation.

2. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation and Petition to Revoke Probation No. 800-2019-062815 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Benjamin J. Fenton. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: November 1,2021

SCOTT EISENKOP, M.D.
Respondent

I have read and fully discussed with Respondent Scott Eisenkop, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 11/1/21

BENJAMIN J. FENTON
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: November 1, 2021

Respectfully submitted,

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

Electronically Signed

VLADIMIR SHALKEVICH
Deputy Attorney General
Attorneys for Complainant

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Accusation and Petition to Revoke Probation
800-2019-062815

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
VLADIMIR SHALKEVICH
Deputy Attorney General
State Bar No. 173955
California Department of Justice
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6538
Facsimile: (916) 731-2117

Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation and Petition to Revoke Probation Against: **SCOTT EISENKOP, M.D.** **29525 Canwood Street, Suite 205** **Agoura Hills, CA 91301-4223** **Physician's and Surgeon's Certificate No. G41053,** Respondent.	Case No. 800-2019-062815 **ACCUSATION AND PETITION TO REVOKE PROBATION**

PARTIES

1. William Prasifka (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about October 15, 1979, the Medical Board issued Physician's and Surgeon's Certificate No. G41053 to Scott Eisenkop, M.D. (Respondent). Physician's and Surgeon's Certificate No. G41053 was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2021, unless renewed.

DISCIPLINARY HISTORY

3. In a disciplinary action entitled, "In the Matter of the Accusation Against: Scott Eisenkop, M.D.," Case No. 17-2012-224090, the Board issued a decision, effective July 9, 2014, in which Respondent's Physician's and Surgeon's Certificate No. G41053 was revoked. However, the revocation was stayed and Respondent's Physician's and Surgeon's Certificate No. G41053 was placed on probation for a period of 10 years with certain terms and conditions. A true and correct copy of that decision is attached as Exhibit A, and is incorporated by reference as if fully set forth herein.

4. In the same disciplinary action referenced in paragraph 3, above, following an Order of Remand to Administrative Law Judge dated August 11, 2015, the Board issued a decision, effective June 16, 2016, in which the terms and conditions of probation relating to Respondent's limitation of work-related hours and utilization of an assistant surgeon or registered nurse first assistant during surgeries were modified. A true and correct copy of that decision is attached as Exhibit B, and is incorporated by reference as if fully set forth herein.

JURISDICTION

5. This Accusation and Petition to Revoke Probation is brought before the Board, under the authority of the following laws and the Board's Decision in Case No. 17-2012-224090. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

6. Section 2227 of the Code states, in pertinent part:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
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> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

...

7. Section 725 of the Code, states, in pertinent part:

(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon...

8. Section 2234 of the Code, states, in pertinent part:

The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

...

9. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

10. At all times after the effective date of Respondent's probation in Case No. 17-2012-224090, Condition No. 12 of Respondent's probation provided the following:

12. Violation of Probation. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction under the matter is final, and the period of probation shall be extended until the matter is final.

FIRST CAUSE FOR DISCIPLINE

(Commission of Any Act of Dishonesty Substantially Related to the Qualifications, Functions, or Duties of a Physician and Surgeon)

11. Respondent has subjected his Physician's and Surgeon's Certificate No. G41053 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (d), of the Code, in that he has committed an act of dishonesty substantially related to the qualifications, functions, or duties of a physician and surgeon, as more particularly alleged hereafter:

12. On or about July 18, 2014, Respondent's Physician's and Surgeon's Certificate was placed on probation. On or about July 23, 2014, Respondent met with his Medical Board probation monitor. They reviewed all the terms of probation, including Respondent's availability for interviews with the Board or its designee.

13. On or about June 16, 2015, Respondent's privileges at Providence Tarzana Medical Center (Tarzana) were summarily suspended for failure to comply with a corrective action plan.

14. On or about August 15, 2015, Respondent met with his Board probation monitor and they reviewed his second quarterly declaration, covering April through June 2015. Respondent told his probation monitor that he was performing surgeries at Adventist Simi Valley Hospital, Los Robles, Hollywood Presbyterian, and Tarzana. Respondent failed to disclose his suspension of privileges from Tarzana Medical Center.

15. From on or about November 19, 2015, through January 11, 2018, in approximately six meetings with his probation monitor, Respondent failed to disclose the suspension of his privileges at Tarzana. On or about June 13, 2018, Respondent finally told his probation monitor

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that his privileges had been suspended at Tarzana, in addition to Adventist Simi Valley Hospital[1] and Los Robles Regional Medical Center.[2]

SECOND CAUSE FOR DISCIPLINE
(Gross Negligence)

16. Respondent has subjected his Physician's and Surgeon's Certificate No. G41053 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he has committed gross negligence in the care and treatment of Patients A and B.[3] The circumstances are as follows:

Patient A

17. On or about August 11, 2017, Patient A, then a 50-year old female, underwent a CT scan of her abdomen and pelvis. Respondent had been treating Patient A since mid-2014. Patient A had a history of recurrent high-grade serous ovarian cancer. She had a history of prior surgeries including a secondary cytoreductive surgery in 2014, splenectomy, abdominal hysterectomy, bilateral salpingo-oophorectomy and low anterior resection. The CT scan on or about August 11, 2017, showed thrombosis and occlusion of the main portal vein with periportal edema as well as a 2 centimeter (cm) low-density lesion in the caudate lobe of the liver, indistinct soft tissue density within the porta hepatis in the region of the portal vein occlusion, abnormal retroperitoneal lymphadenopathy[4] at the level of the kidneys extending along the common and external iliac chains including an 8 millimeter (mm) left common iliac lymph node causing left hydronephrosis,[5] a 3.1 cm mass within the right mesentery in addition to smaller numerous

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[1] Respondent's privileges were suspended from Adventist Simi Valley Hospital on or about January 8, 2018. Respondent first disclosed this suspension to his Board probation monitor on or about June 13, 2018, when he reviewed his first quarterly declaration of 2018 with his Board probation monitor.

[2] Respondent's privileges were suspended from Los Robles Regional Medical Center on or about November 29, 2017. Respondent first disclosed this suspension to his Board probation monitor on or about January 11, 2018, when he reviewed his fourth quarterly declaration of 2017 with his Board probation monitor.

[3] Letters are used to protect the patients' privacy. Respondent is aware of their identities.

[4] Lymphadenopathy is the swelling of the lymph nodes.

[5] Hydronephrosis is a condition in which there is an excess amount of fluid in the kidney due to a backup of urine. It is caused by a blockage in the ureter.

mesenteric nodules, up to 1.9 cm in size, and bilateral enlarged inguinal lymph nodes measuring up to 2.3 cm.

18. On or about August 22, 2017, Patient A was admitted to the hospital for a planned secondary cytoreduction,[6] possible bowel resection, and possible fecal diversion with Respondent. On or about the same day, at approximately 1230, Respondent performed a colorectal resection and low anastomosis with end colostomy,[7] bilateral ureteral dissection with resectioning, portal vein cytoreduction, and secondary cytoreduction. In his operative report, Respondent documented that all visible disease had been resected. He also documented that the hernia sac was resected and sent to pathology. According to the pathology records, Respondent sent 10 specimens to the lab which contained high-grade metastatic carcinoma consistent with high-grade serous ovarian cancer. Respondent failed to document these 10 specimens in his operative report. Respondent signed the operative note for this surgery on or about August 26, 2017. On or about September 27, 2017, Respondent created an addendum to the operative report, adding that he resected a portion of the ileum and more proximal small bowel due to enterolysis bleeding, adhesions, and devascularization.

19. Following the surgery, on or about August 22, 2017, at approximately 2318, G.G., M.D., examined Patient A in the Post-Anesthesia Care Unit (PACU). G.G., M.D., reviewed Patient A's labs and chest x-ray. G.G., M.D., noted that Patient A's plan of care was discussed with Respondent.

20. On or about August 23, 2017, Respondent saw Patient A for his first documented post-operative visit. He noted that she had reasonable pain control, and that he spoke to Patient A and her family in detail about the surgery.

21. From on or about August 25, 2017, through September 1, 2017, Respondent saw Patient A in the hospital every day or two. During this period of time, Patient A reported no ostomy output and some flatus. Respondent ordered a clear liquid diet on or about August 28, 2017.

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[6] Cytoreduction is a surgical procedure to remove all visible tumors.

[7] A colostomy is a surgically created opening of the colon which is brought to the abdominal wall.

22. On or about September 1, 2017, an x-ray of Patient A's abdomen showed no definite bowel dilation to suggest an obstruction.

23. On or about September 3, 2017, Respondent noted that Patient A still had no ostomy output and could not tolerate any fluids by mouth. Respondent's plan was to order a CT scan with oral contrast.

24. On or about September 3, 2017, another x-ray was taken of Patient A's abdomen. The radiologist found possible obstruction or ileus.

25. On or about September 3, 2017, a CT scan with oral contrast showed an enlarged right axillary lymphadenopathy measuring 3.7 cm, portal vein thrombosis and a low attenuation lesion within the central aspect of the liver measuring 3.1 cm, which, when compared to a prior study, had increased. New moderately distended loops of large and small bowel were noted, as were non-distended bowel loops near the ostomy site, which was consistent with obstruction versus ileus.[8]

26. On or about September 4, 2017, Respondent again noted that Patient A still had no ostomy function or gas. He spoke to Patient A about the possibility of another surgical procedure.

27. From on or about September 5, 2017, through September 9, 2017, Respondent saw Patient A every day. Patient A still had no ostomy function.

28. On or about September 10, 2017, Respondent noted, "ileus vs SBO [small bowel obstruction] on CT with no demonstration of enteric leakage."

29. On or about September 11, 2017, Patient A still had no normal gastrointestinal function. Respondent's plan was to consider an upper/lower endoscopy.

30. On or about September 12, 2017, G.J., M.D., conferred with radiologists and determined that Patient A's symptoms were consistent with a transverse colon obstruction. G.J., M.D., ordered a gastrografin study,[9] which was done on or about the same day. The study

[8] Ileus is the lack of movement in the intestines.

[9] For a gastrografin study, the patient swallows gastrografin contrast material which is visible by x-ray. It is used to show the gastrointestinal tract.

showed antegrade flow of contrast through the rectosigmoid colon, and no retrograde flow into the colon or small bowel proximal to the colostomy.

31. On or about September 12, 2017, Respondent saw Patient A and reviewed the gastrografin study. He noted that Patient A had a distal obstruction. His plan was to operate and revise the ostomy.

32. On or about September 13, 2017, Respondent performed a partial colectomy, colostomy revision, extensive enterolysis, and small bowel repair. According to Respondent's operative report, the ostomy site and adjacent compromised bowel were removed. The operative report once again described a hernia sac resection which was sent to pathology. Respondent documented that one Blake drain was placed in the right upper quadrant, contradicting the nursing notes that described three separate drains in the right upper, left upper, and left lower quadrants. Final pathology reported on or about September 15, 2017, showed metastatic poorly differentiated carcinoma involving tissue of the resected sigmoid colon.

33. From on or about September 14, 2017, through September 17, 2017, Respondent saw Patient A in the hospital three times. Patient A reported having ostomy function. She also reported a leak.

34. On or about September 20, 2017, Respondent documented that Patient A had ostomy function but "irregular placement." He noted that the status of the ostomy was uncertain.

35. On or about September 28, 2017, G.J., M.D., ordered a CT with oral contrast. The study showed oral contrast in the jejunum but no contrast in the right colon and distal small bowel, suggestive of a jejunocutaneous fistula.[10] Patient A was put on bowel rest with total parenteral nutrition[11] and a nasogastric tube.

35. On or about September 30, 2017, G.J., M.D., conferred with another physician and confirmed the presence of a fistula.

36. On or about October 24, 2017, a CT scan of the abdomen and pelvis with contrast ordered by Respondent showed the following: thrombosis of the portal vein, a mass at the porta

[10] A jejunocutaneous fistula is an aberrant connection between the GI tract and skin or a wound.

[11] TPN is a method of feeding that bypasses the gastrointestinal tract.

hepatis, and numerous liver lesions; numerous mesenteric masses that had markedly increased in size in the superior small bowel mesentery; abnormally enlarged inguinal and left external iliac lymph nodes; and lack of contrast opacification of the small bowel.

37. On or about October 27, 2017, a repeat CT scan of the abdomen and pelvis with contrast was performed. A bowel enterocutaneous fistula was indicated when the colon did not opacify with contrast. Additional surgery to correct the fistula was discussed with Patient A, who declined in favor of palliative care, given her poor prognosis.

38. Respondent committed gross negligence in his care and treatment of Patient A which includes, but is not limited to, the following:

a. Respondent decided to proceed with surgery, despite clinical evidence of widespread recurrence of disease on August 11, 2017, and Respondent failed to provide Patient A with the alternatives to surgery including salvage treatment;

b. Respondent failed to perform a technically sound bowel surgery and create a stoma from the proximal end of the Hartmann's pouch;

c. Respondent delayed and initially failed to diagnose the ostomy malfunction following the initial surgery on August 22, 2017; and

d. Respondent failed to enter timely and accurate records documenting the operation on or about August 22, 2017.

Patient B

39. Patient B, then a 63-year old female, was diagnosed with ovarian cancer in December 2006.[12] On or about December 14, 2006, Respondent operated on Patient B at which point she was diagnosed with high-grade serous ovarian cancer involving the right ovary and fallopian tube with extensive lymphovascular invasion and involvement of multiple pelvic and para-aortic lymph nodes.

40. Following surgery on or about December 14, 2006, Patient B underwent four rounds of chemotherapy from approximately December 2006 through April 2007.

[12] Conduct occurring more than seven (7) years from the filing date of this Accusation or more than three (3) years from notification to the Board is for informational purposes only and is not alleged as a basis for disciplinary action.

41. On or about May 25, 2007, Patient B underwent an exploratory laparotomy by Respondent to assess for disease response. During the procedure, there was extensive lysis of intestinal adhesions and multiple biopsies taken. All 31 specimens biopsied from this procedure were negative for metastatic carcinoma. Patient B then completed radiation therapy in or around August 2007 with Dr. M.

42. On or about May 30, 2008, a follow up PET/CT scan showed a hypermetabolic one cm suspicious lymph node between the left common iliac vessels and iliopsoas.

43. In or around August 2008, a CT scan showed persistent left pelvic sidewall lymphadenopathy.

44. On or about September 26, 2008, Patient B underwent her third exploratory laparotomy by Respondent. Extensive lysis of adhesions with repair of multiple seromuscular bowel defects were noted. A frozen section of resected left common iliac lymph node showed metastatic carcinoma. All other specimens biopsied were negative for carcinoma. Following this procedure, Patient B recuperated in the intensive care unit.

45. Between approximately October 2008 through January 2009, Patient B underwent multiple cycles of chemotherapy, which was complicated by platelet issues.

46. In approximately August 2009, a follow up PET/CT scan showed no evidence of disease.

47. On or about June 11, 2010, a follow up PET/CT scan showed hypermetabolic lymphadenopathy.

48. On or about June 25, 2010, Patient B underwent her fourth exploratory laparotomy by Respondent. Once again, extensive adhesiolysis was noted. A nodule within the mesentery was resected and shown to have metastatic adenocarcinoma on frozen section. Respondent performed right and left ureterolysis to remove the right common iliac vessel and presacral metastatic lymph nodes. Patient B recuperated in the intensive care unit.

49. From approximately August 2010 to February 2011 and April 2011 through January 2012, Patient B completed multiple cycles of chemotherapy and Avastin maintenance therapy. From approximately April 2012 to December 2012, treatment was suspended due to hypertension

and decreased renal function. Avastin treatment was attempted again but discontinued due to worsening kidney function.

50. On or about September 2, 2011, a follow up PET/CT scan showed multiple hypermetabolic lymph nodes, including a 1.7 cm aortocaval lymph node which had decreased in size and metabolic activity, and a 1.2 cm lymph node at the bifurcation of the iliac vessels.

51. A follow up CT scan of the pelvis in or around February 2012, and PET/CT scans in approximately June 2012, and September 2012, did not indicate the presence of active disease.

52. On or about March 25, 2014, a follow up PET/CT scan showed multiple metabolically active lymph nodes through the retroperitoneum, including a 1.4 cm left common iliac artery lymph node, a 1.7 cm right common iliac lymph node, a 1.2 cm left common iliac lymph node, and others adjacent to the root of the mesentery.

53. On or about April 15, 2014, Patient B underwent her fifth exploratory laparotomy by Respondent. Once again, extensive adhesiolysis was noted and a small bowel section was done due to adhesions of the small bowel to the right pelvic sidewall. Respondent performed a right extensive ureterolysis due to stricturing of the right ureter. Respondent removed the right external iliac and common iliac lymphadenopathy, which showed metastatic adenocarcinoma on frozen section. The right precaval, perirenal, left aortic, left common and left aortic lymph nodes were also removed, and were positive for metastatic adenocarcinoma.

54. From on or about April 24, 2014, through October 2014, Patient B received multiple cycles of chemotherapy.

55. On or about October 8, 2014, Respondent noted that Patient B's last two cycles of chemotherapy were in lieu of additional cytoreductive surgery.

56. On or about December 12, 2014, a follow up PET/CT scan showed that the right iliac artery, left common iliac artery, and mesenteric lymphadenopathy had normalized and decreased in size.

57. In approximately June 2016 and December 2016, follow up PET/CT scans showed slowly enlarging and increasingly hypermetabolic lymphadenopathy medial to the inferior vena cava and along the right common iliac lymph node.

58. On or about August 9, 2017, a follow up PET/CT scan showed a 1.7 cm hypermetabolic gastrohepatic ligament lymph node and an enlarged hypermetabolic mesenteric 1.3 cm lymph node in Patient B's pelvis, and a questionable enlarging 8 cm right common iliac lymph node.

59. On or about August 17, 2017, Patient B saw L.A., M.D., a cancer and blood specialist in New York. L.A., M.D., talked to Patient B about the increasing size and metabolic activity of the lymph nodes and offered a number of treatment options other than surgery.

60. On or about October 26, 2017, Patient B saw Dr. M., a physician who oversaw some of her prior chemotherapy treatments. Dr. M. recommended a six month follow up without any additional therapy.

61. On or about November 9, 2017, Patient B saw Respondent at his office. Respondent noted that Patient B's CA-125 and HE4[13] levels were slightly up.

62. On or about November 15, 2017, a follow up PET/CT scan showed several lymph nodes in the abdomen and pelvis that had mildly increased in size and metabolic activity since December 2016, which was concerning for increasing metastatic disease. Images from August 2017 were later obtained and reviewed for comparison. The radiologist determined that the lymphadenopathy in the abdomen and pelvis had not significantly changed with the exception of the lymph node near the right common iliac artery.

63. On or about November 16, 2017, Patient B returned to Respondent's office. He noted that Patient B's CA-125 was slightly rising and that her HE4 was down. Respondent also noted the PET/CT scan showing significant risk of recurrent ovarian cancer. Respondent conferred with Dr. C., an interventional radiologist, who said that it was not feasible to do a CT-guided biopsy. The plan was to schedule a secondary/tertiary cytoreduction. Respondent failed to document any discussion with Patient B about the risks, benefits, and alternatives to surgery or about the possibility to obtain a second opinion.

[13] CA (cancer antigen) 125 and HE4 (human epididymis protein) are proteins that are found in greater concentration in ovarian cancer cells than in other cells.

64. On or about November 21, 2017, Patient B saw Respondent. Respondent again noted that Patient B's lymph nodes were not amenable to image guided biopsy. He talked to Patient B about surgery to rule out inflammation versus disease recurrence. Respondent failed to document any discussion with Patient B about the risks, benefits, and alternatives to surgery or about the possibility to obtain a second opinion.

65. On or about November 22, 2017, Respondent documented a history and physical examination for Patient B. While Respondent noted that all risks, benefits, and alternatives to the procedure were discussed with Patient B, Respondent failed to document what was actually discussed.

66. Patient B's sixth exploratory laparotomy was initially scheduled for December 1, 2017, at Los Robles Regional Medical Center. On or about November 20, 2017, however, Respondent's hospital privileges were suspended at Los Robles, and the surgery was subsequently canceled.

67. On or about December 28, 2017, an MRI of Patient B's abdomen and pelvis showed a stable right common iliac 1.3 cm lymphadenopathy and a 7 mm retrocrural lymph node. Patient B's CA 125 and HE4 levels in July, October, November, and December 2017 were 21 and 194, 25 and 209, 23 and 29, and 19 and 141, respectively.

68. On or about January 3, 2018, Patient B underwent her sixth exploratory laparotomy by Respondent at Adventist Simi Valley. According to the anesthesia records, a frozen section was sent to pathology at approximately 1558. This was not documented in Respondent's operative report. Respondent noted a right hydroureter[14] at the level of the common iliac vessel was dissected and a rent in the inferior vena cava was repaired. There was no mention of the use of indigo carmine or methylene blue to identify any ureteral leaks. In the operative report, Respondent noted that the blood loss was 1,000 ccs, while the anesthesia record states that there was 2,000 cc of blood loss, requiring multiple red blood cell, platelet, and fresh frozen plasma

[14] Hydroureter is dilation of the ureter and is most often caused by an obstruction of urine outflow due to blockage, chronic inflammation, luminal or intramural neoplasia, or accidental ligation during surgery.

transfusions. Following surgery, Patient B was admitted to the ICU due to excess intraoperative blood loss.

69. On or about January 3, 2018, at approximately 1930, a nurse documented that she notified Respondent of Patient B's increased drain output. Respondent ordered hematocrit and creatinine tests from the drain. Patient B's drain creatinine measured 8 mg/dL, indicating a probable urinary leak.

70. On or about January 4, 2018, Patient B was extubated and transferred from intensive care to the telemetry unit on or about January 5, 2018.

71. On or about January 5, 2018, Respondent acknowledged the abnormal drain creatinine and possible ureteral leak. He noted that Patient B should "strongly consider" a stent placement.

72. On or about January 5, 2018, M.M., M.D., a consulting urologist, recommended monitoring of Patient B's creatinine and drain output.

73. On or about January 5, 2018, pathology determined that the biopsies taken during surgery showed fibrofatty tissue with scar-like fibrosis and suture material. No malignancy or lymphatic tissue was noted.

74. On or about January 6, 2018, a CT of Patient B's abdomen and pelvis showed fluid density in the mid right kidney, probably showing a right renal cyst measuring less than 2 cm.

75. On or about January 14, 2018, because Patient B's creatinine levels continued to rise, a nuclear medicine renal scan was done. It showed possible right hydronephrosis with delayed right renal excretion, with normal blood flow to both kidneys.

76. On or about January 15, 2018, M. M., M.D., noted the increased creatinine output and recommended cystoscopy,[15] which was performed on or about January 16, 2018.

77. During the cystoscopy, the urologist noted a normal right lower ureter with extravasation of contrast at the mid ureter above the iliac vessels without filling the right renal pelvis. A stent was placed to correct the leak. The left ureter was found to be normal. Patient B ultimately recovered and was discharged on or about January 23, 2018.

[15] Cystoscopy is endoscopy of the urinary bladder via the urethra.

78. Respondent committed gross negligence in his care and treatment of Patient B which includes, but is not limited to, the following:

a. Respondent decided to proceed with Patient B's sixth surgical procedure despite the possibility of complete surgical resection of disease being remote;

b. Respondent failed to document the indications of the sixth surgery and details of any discussions with Patient B regarding the risks, benefits, and alternative treatment options.

THIRD CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

79. Respondent has further subjected his Physician's and Surgeon's Certificate No. G41053 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he has committed repeated negligent acts in the care and treatment of Patient A and Patient B, as more particularly alleged in paragraphs 17 through 78, above, which are incorporated by reference and re-alleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE
(Excessive Utilization of Treatment Facilities)

80. Respondent has further subjected his Physician's and Surgeon's Certificate No. G41053 to disciplinary action under sections 2227 and 725 of the Code, in that he repeatedly performed unnecessary surgery on Patient B, as more particularly alleged in paragraphs 39 through 79, above, which are incorporated by reference and re-alleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE
(Failure to Maintain Adequate and Accurate Records)

81. Respondent has further subjected his Physician's and Surgeon's Certificate No. G41053 to disciplinary action under sections 2227 and 2266 of the Code, in that he has failed to maintain adequate and accurate records for Patient A and Patient B, as more particularly alleged in paragraphs 17 through 79, above, which are incorporated by reference and re-alleged as if fully set forth herein.

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FIRST CAUSE TO REVOKE PROBATION
(Failure to Obey All Laws)

82. At all times after the effective date of Respondent's probation in Case No. 17-2012-224090, Condition No. 7 of Respondent's probation provided:

> 7. Obey All Laws. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

83. Paragraphs 11 through 81, above, are hereby incorporated by reference and re-alleged as if fully set forth herein.

SECOND CAUSE TO REVOKE PROBATION
(Failure to Abide by the Conditions regarding the Limitation of Work-Related Hours)

84. At all times on or after the effective date of Decision and Order after Remand on June 16, 2016, Condition No. 3 of Respondent's probation provided, in pertinent part:

> 3. Limitation on Work-Related Hours. Respondent shall limit his work-related hours to periods of no more than 10 consecutive hours. "Work-related hours" is modified to define those hours in which Respondent is performing any of the duties of a physician and surgeon including but not limited to performing surgery, assisting in surgical procedures, giving other medical treatment, consultation with patients, other physicians, and other medical personnel, patient examination, travel to and from office and hospitals for patient care, chart and/or report writing, teaching, and medical research. Time spent in between "work-related hours" in which Respondent is not engaged in work-related activities and the time waiting for a surgery to commence, shall not be considered "work-related hours" unless that time exceeds three hours, individually or collectively if multiple surgeries are scheduled the same day.
>
> The cessation of any consecutive work-related hours, even if fewer than 10 consecutive hours, shall be followed by no fewer than nine consecutive hours spent in activities other than performing the duties of a physician and surgeon. This condition is intended to ensure Respondent receives adequate rest so as to minimize the risk of seizures during work-related hours.
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> Respondent shall not schedule any surgeries or other work-related activities in a manner that may risk his having to perform work-related activities following the 10 consecutive hour allotment. This condition of probation shall not apply to emergent cases. However, within 24 hours of completion of any such emergent surgery, Respondent shall notify the Board or its designee that he performed an emergent procedure following the expiration of the 10 consecutive hour work-related allotment, the nature of the case, why Respondent considered the case emergent, and why he believed the procedure could not have been performed on an urgent basis within a 10 consecutive hour work-related allotment without placing the patient at undue risk. Any emergent procedure that requires Respondent to engage in work-related activities beyond the 10 consecutive hour work-related allotment shall be followed by no fewer

than nine consecutive hours of non-work-related time.

...

The failure of Respondent to comply with all aspects of this condition shall be considered a violation of probation.

85. On or about February 12, 2016, Respondent documented that he worked from 7:30 a.m. to 11:00 p.m. Respondent failed to notify his probation monitor of this emergent event within 24 hours per the probation term. Instead, Respondent notified his probation monitor on or about February 14, 2016.

86. On or about June 22, 2016, Respondent documented that he worked from 7:00 a.m. to 8 p.m. He also documented 13 hours of work-related time, and 0 hours of non-work-related time. Respondent failed to provide written documentation to his probation monitor for going over his 10-hour work restriction.

87. On or about January 5, 2017, Respondent documented that he worked from 8:45 a.m. to 11:45 p.m. Respondent failed to notify his probation monitor within 24 hours, emailing him instead on or about January 8, 2017.

88. On or about June 9, 2017, Respondent documented that he worked from 7:00 a.m. to 9:45 p.m. Respondent failed to provide written documentation to his probation monitor for going over his 10-hour work restriction.

89. On or about August 29, 2017, Respondent documented that he worked from 7:00 a.m. to 9:30 p.m. Respondent failed to notify his probation monitor within 24 hours, emailing him instead on or about August 31, 2017.

90. On or about November 13, 2017, Respondent documented that he worked from 8:30 a.m. to 10:30 p.m. Respondent failed to notify his probation monitor of going over his 10-hour work restriction within 24 hours per the probation term.

91. On or about September 6, 2018, Respondent documented that he worked from 7:30 a.m. to 9:30 p.m. for a total of 14 hours. Respondent failed to notify his probation monitor of going over his 10-hour work restriction within 24 hours per the probation term.

92. On or about March 8, 2018, Respondent documented that he finished work at 6:00 p.m. On or about March 9, 2018, Respondent worked from 12:30 a.m. to 4:30 a.m. on an

emergent case. On or about the same day, Respondent went back to work to see patients in his office at 1:00 p.m., in violation of the terms of probation which require a minimum of nine consecutive hours of non-work related time before resuming practice. In an email to his probation monitor entitled, "emergency whatever that means," Respondent failed to document the nature of the case, why he believed the case to be emergent, and why he believed the procedure could not have been performed on an urgent basis within a 10 consecutive hour work-related allotment without placing the patient at undue risk. Respondent also failed to explain whether seeing his patients in his office in the afternoon of March 9, 2018, was emergent.

THIRD CAUSE TO REVOKE PROBATION
(Failure to Comply with Probation Unit)

93. At all times after the effective date of Respondent's probation in Case No. 17-2012-224090, Condition Nos. 8 and 9 of Respondent's probation provided:

> 8. Quarterly Declarations. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.
>
> ...
>
> 9. Compliance with Probation Unit. Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

94. On all quarterly declaration forms provided by the Board, Respondent is required to provide detailed explanations on a separate piece of paper should he answer yes to questions 1 through 10.

95. From on or about April 4, 2015, through July 12, 2018, on approximately 13 quarterly declaration forms, Respondent answered "yes" to Question 4, which asked whether there were any civil suit, malpractice, or peer review proceedings pending against Respondent. Contrary to the instructions on the form, Respondent failed to submit any written explanations providing more detailed information for his answers in the affirmative.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. G41053, issued to Respondent Scott Eisenkop, M.D.;

2. Revoking the probation that was granted by the Medical Board of California in Case No. 17-2012-224090, and imposing the disciplinary order that was stayed, thereby revoking Physician's and Surgeon's Certificate No. G41053, issued to Respondent Scott Eisenkop, M.D.;

3. Revoking, suspending, or denying approval of Respondent Scott Eisenkop, M.D.'s authority to supervise physician assistants and advanced practice nurses;

4. Ordering Respondent Scott Eisenkop, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

5. Taking such other and further action as deemed necessary and proper.

DATED: 12/10/2020

Jennie Jones for William Prasifka

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

LA2020500089
Eisenkop Accusation with analyst edits.docx

Exhibit A

Decision In the Matter of the Accusation Against: Scott Eisenkop, M.D.,
Case No. 17-2012-224090, effective July 9, 2014

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
SCOTT EISENKOP, M.D.	Case No. 17-2012-224090
Physician's and Surgeon's Certificate No. G41053	OAH No. 2013060333
Respondent	

DECISION

The attached Proposed Decision is hereby amended, pursuant to Government Code section 11517(c)(2)(c) to correct technical or minor changes that do not affect the factual or legal basis of the proposed decision. The proposed decision is amended as follows:

1. Page 7, paragraph 24 – the date of May 21, 2013 in the first sentence will be corrected to "May 21, 2012."

The attached Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on July 9, 2014.

IT IS SO ORDERED: June 9, 2014.

MEDICAL BOARD OF CALIFORNIA

BARBARA YAROSLAVSKY, Chair
Panel A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
SCOTT EISENKOP, M.D.	Case No. 17-2012-224090
Physician's and Surgeon's Certificate Number G 41053	OAH No. 2013060333
Respondent.	

PROPOSED DECISION

This matter came on regularly for hearing on April 21-25, 2014, in Los Angeles, California, before H. Stuart Waxman, Administrative Law Judge, Office of Administrative Hearings, State of California.

John E. Rittmayer, Deputy Attorney General, represented Complainant, Kimberly Kirchmeyer (Complainant), Executive Director of the Medical Board of California (Board).

Respondent was present and was represented by Benjamin J. Fenton, Attorney at Law.

Oral and documentary evidence was received. The record was closed on April 25, 2014, and the matter was submitted for decision.

Complainant brought this action to limit Respondent's practice on grounds that his ability to practice safely is impaired because he suffers a physical illness affecting competence pursuant to Business and Professions Code section 822. For the reasons set forth below, Respondent's practice will be so limited.

FACTUAL FINDINGS

1. Complainant filed the Accusation in her official capacity.

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2. On a date not disclosed by the evidence,[1] the Board issued Physician's and Surgeon's Certificate Number G 41053 to Respondent. The certificate was in full force and effect at all relevant times. It will expire on March 31, 2015, unless renewed.

Respondent's Background

3. Respondent is a gynecologic oncologist certified by the American Board of Obstetrics and Gynecology, Division of Gynecologic Oncology. After graduating summa cum laude from the University of California, Los Angeles (UCLA), he earned his doctorate at the Chicago Medical School and served his internship and residency at the Los Angeles County/University of Southern California (LAC/USC) Medical Center and a fellowship with the Division of Gynecologic Oncology, Department of Obstetrics and Gynecology at the UCLA Medical Center. Respondent has served on the medical faculties at UCLA and Stanford University. He is extensively published.

4. Respondent enjoys a reputation as an extraordinary surgeon. He is one of the few gynecologic oncologists who practices in the San Fernando Valley. His practice extends west to Thousand Oaks. He is called in regularly by gynecologists to perform surgeries ranging from relatively simple procedures to the most complex. His surgeries tend to be more urgent than emergent. Respondent presently has privileges at five hospitals but performs most of his surgeries at only two.

5. Respondent is dedicated to his profession. He makes himself available to referring physicians at all times. He is willing to, and often does, work long hours including well into the night, and he is willing to trade sleep time in order to treat a patient in need.

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[1] Respondent's certificate was not offered into evidence. Factual Finding 2 is made on the basis of a stipulation between the parties (Exhibit 2). However, the issuance date is not included in the stipulation. Additionally, according to the Stipulation, Respondent's certificate number is A 86869. That number is incorrect. The correct certificate number, as reflected in the Accusation, is G 41053.

6. In 1996, Respondent underwent chemotherapy and radiation for lymphoepithelioma of the nasopharynx. Although the treatment was successful, it left him with xerostomia (dry mouth), tightened jaw muscles, and bilateral hearing loss. He is unable to fully open his mouth, and he is unable to drink through a straw. The area surrounding his mouth is numb. He has difficulty speaking clearly, and extended or extensive speaking creates more dryness in the mouth and increased slurring of his speech. Due to these conditions, Respondent insists on quiet in the operating room, and he prefers to work with the same people consistently because they are familiar with his limitations and are able maintain quiet and anticipate his needs, thus enabling him to hear better and speak less frequently. He also prefers to work with individuals who do not have a "language barrier" (Respondent's term) because he believes such individuals' accents make it more difficult for him to understand them and for them to understand him, thus requiring him to use his voice more than would otherwise be necessary. Those who do not regularly work with Respondent sometime find his personality and his fierce commitment to surgical excellence caustic and demanding.

7. Respondent can relieve his xerostomia to a certain extent by drinking water, which he does regularly, and by remaining silent, thereby allowing the moisture in the air inside his mouth to moisten the surrounding mucous membranes. Although he denies ever drinking water during surgery, two of the regular registered nurse first assistants with whom he has regularly worked for years have known him to do so. Some of the staff members with whom he regularly works are familiar with a set of hand signals Respondent has devised, and Respondent is able to save his voice by using those signals. However, he is unable to do so when working with someone unfamiliar with the signals.

8. In 2008, Respondent was participating in grand rounds when he suffered a seizure that precluded his ability to speak for approximately three minutes. He experienced two or three similar episodes in the ensuing months. Since that time, he has been under the care of neurologist, Arthur Kowell, M.D., for simple partial seizure disorder. Dr. Kowell presently has Respondent on therapeutic doses of Topamax and Keppra. With those medications, Respondent's seizure activity is well-controlled. However, the likelihood of a recurrence of seizure activity is increased by Respondent's maintaining extended work hours and not getting enough sleep.

9. Respondent's seizure disorder involves only speech arrest, a condition in which he is unable to form words. The condition lasts from a few seconds to a few minutes.

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The Surgery of May 21, 2012

10. On May 21, 2012, Respondent was scheduled to assist on an urgent surgery involving laparoscopic lysis of adhesions and removal of one ovary. The surgery was to take place at St. Joseph's Medical Center in Burbank, one of approximately eight hospital at which Respondent had privileges. Although the patient's regular gynecologist, David Ahdoot, M.D., was scheduled as the lead surgeon, Respondent served in that capacity due to the complexity of the procedure. Both Dr. Ahdoot and Respondent had seen the patient before and were familiar with her history and present condition.

11. That day had been a busy one for Respondent. He had performed an extensive surgery in the morning and he had been busy with office visits thereafter.

12. The surgery was scheduled to commence at approximately 5:30 p.m., but was delayed until approximately 7:00. Because of the late start time, the surgical staff assigned to the case was not the staff with whom Respondent regularly worked. However, circulating nurse, Karen Rhodes (Rhodes), and surgical technician (scrub tech), Jorge Ochoa (Ochoa), had worked with Respondent many times over the prior few years and were familiar with his preferences. English is a second language for Ochoa, and he speaks with an accent. For that reason, Respondent has found it difficult to work with him, and he had previously requested the hospital not to assign Ochoa to any of his cases.

13. Lysing the adhesions and repairing small nicks in the bowel was a slow, meticulous process lasting several hours. Respondent and Dr. Ahdoot then discovered that, during an earlier tummy tuck procedure, a surgeon had sutured part of the bowel to the abdominal wall with permanent sutures. This would require conversion of the procedure from a laparoscopy to an open laparotomy. The staff began to assemble the appropriate instrumentation for the new procedure. At the same time, some new operating room personnel arrived for shift change and received report from those going off duty. The noise level in the operating room up to that time had been quiet with minimal conversation. However, at that point, the noise volume in the operating room necessarily increased.

14. At approximately 10:24 p.m., while those changes were occurring and after the abdomen had been opened, Respondent stopped operating and became still and silent. After a few moments, he attempted to utter a few words no one in the room could understand. The anesthesiologist, Rhodes, Ochoa, and Dr. Ahdoot, each attempted to clarify what Respondent had said, but Respondent did not respond except to utter a few more incomprehensible and apparently unrelated words Rhodes described as a "mumble of consonants." They asked if he meant specific things, but again, they received only incoherent mumbles in response. Ochoa found Respondent confused, incoherent, and disoriented. He had never seen Respondent act in that manner before. Dr. Ahdoot suggested Respondent step back from the table and have a seat. Respondent was offered water or juice. However, he remained at the operating table and began to operate again. Dr. Ahdoot left the operating room for some water. He asked Rhodes to assist him in telephoning Respondent's partner, Dr. Lin.

15. The episode lasted 10-15 minutes. Upon Dr. Ahdoot's return to the operating room, Respondent continued to operate having never left the table. At one point, Respondent asked Ochoa, "What are we doing here" and "Why don't we just close" or words to that effect. Dr. Lin arrived shortly before closing began. The remainder of the surgery was uneventful, and Dr. Lin was not an active participant.

16. At one point late in the surgery, Respondent asked Rhodes for his history and physical (H&P). She gave him the H&P Dr. Ahdoot had prepared. Respondent rejected it and asked for the one he had prepared. Rhodes was unable to locate an H&P prepared by Respondent. However, it was Respondent's custom and practice to prepare an H&P for every surgery he performed and to look at it late in the surgery to ensure he had accomplished all he had planned. Therefore, the issue of the H&P is not viewed as part of the episode described in Factual Findings 14 and 15, above.

17. Also before the end of the surgery, Respondent asked the anesthesiologist if he had inserted an NG tube. Respondent had already ordered the anesthesiologist to place an NG tube at the beginning of the surgery. However, it was Respondent's custom and practice to ask again at the end of surgery, especially when bowel resection was involved, as it was in this case. Accordingly, Respondent's question to the anesthesiologist is not viewed as part of the episode described in Factual Findings 14 and 15, above.

18. However, following the surgery, Respondent asked Rhodes if the circulating nurse was still present. Except for the removal of her surgical mask, Rhodes was dressed as she had been during the lengthy surgery, and Respondent appeared not to recognize her. At the hearing, Respondent claimed there had been another circulating nurse present during the surgery. That assertion lacks merit in that it was specifically denied by Rhodes, who was likely to know which staff members were present. In addition, Respondent recalls speaking with Rhodes at the end of the surgery. It is unlikely Rhodes would still be there following the surgery if she had been relieved intra-operatively.

19. Respondent's version of the events of May 21, 2012 is much different. He testified that the problems in the operating room began at the beginning when he arrived to find that many of the instruments he needed for the laparoscopy where either missing or not plugged in, and that, when he stated he needed an omni, the circulating nurse (Rhodes) was not familiar with that device and had to go look for one. That testimony was not convincing in that (1) Dr. Ahdoot had arrived before Respondent and had not noticed any inadequacy in the instrumentation, and (2) Rhodes is an experienced circulating nurse with a Bachelor of Science in Nursing (BSN). It is extremely unlikely that she would be unfamiliar with an instrument as common as an omni.

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20. Respondent testified that the atmosphere in the operating room throughout the procedure was tense, hostile, and extremely noisy. The temperature in the room was hot, and he repeatedly had to ask for quiet throughout the procedure. Respondent's description stands in sharp contrast to the testimony of both Rhodes and Ochoa, who testified that they were aware of Respondent's preference for quiet, and that the entire staff maintained a quiet atmosphere during the procedure. It is also contrary to Dr. Ahdoot's testimony. Dr. Ahdoot testified that the noise level increased only during the shift change and instrument change, both of which occurred around the time the procedure was converted from a laparoscopy to an open laparotomy.

21. Respondent testified that, around the time he started to open the abdomen, his mouth was very dry. He rested his voice for three to four minutes. During that time, the staff repeatedly asked him if everything was alright, and he answered "Yes. I'm resting my voice." However, his speech was slurred and it sounded like mumbling. Respondent continued to operate while the staff continued to question him. He was never confused or disoriented. There was a great deal of telephone use by the staff and the anesthesiologist. He told them to stop using the telephone. At one point, the anesthesiologist actually left the patient to use his cell phone. Respondent claimed he stopped operating twice during the procedure, once when staff was changing shift, and once when they were assembling the needed instrumentation for the laparotomy. He was "frustrated" (Respondent's term) and wanted to finish the surgery. Respondent also testified that the circulating nurse kept pushing a wheeled trash cart around the operating room, and he instructed her to stop doing so. Further, his questions to Ochoa as to what they were doing there and why they shouldn't close were intended to lighten the mood and as mild sarcasm to motivate Ochoa to better perform his duties.

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22. Respondent's testimony in that regard was not convincing for the following reasons: (1) Respondent was the only one in the operating room that night who testified that the episode lasted only three to four minutes. That testimony was contradicted by both the circulating nurse and the scrub tech who also credibly contradicted Respondent's testimony about the tense and hostile atmosphere in the operating room. Dr. Ahdoot opined that the atmosphere was tense only around the time the procedure changed from a laparoscopy to a laparotomy. (2) Respondent could have easily answered the staff's questions as to whether he was alright with a nod of his head. He did not do so. (3) The only telephone referenced throughout the administrative hearing was outside of the operating room, and the testimony from all concerned, except Respondent, is that it was used only once. That call went to Dr. Lin. No evidence was offered to support the continued use of a telephone in the operating room that was causing unwanted noise, and no evidence was offered to support the need for any telephone use except for the call to Dr. Lin. (4) Respondent's description of his volitional decision to stop operating during the shift change was described by Ochoa as Respondent being somewhat frozen in place (Rhodes testified that he did not look "frozen") and by Dr. Ahdoot as Respondent being very still. (5) Before giving his testimony at the administrative hearing, Respondent never mentioned Rhodes pushing a trash cart around the operating room or the anesthesiologist using his cell phone during surgery and leaving his patient in order to do so. Following the incident, Respondent wrote a letter to the Medical Executive Committee (MEC) of St. Joseph's Medical Center and was subsequently interviewed by the committee, but he did not mention any of those events in either the letter or the interview. Respondent's embellishment of his story only at its most recent telling reflects poorly on his credibility. The descriptions of the event of May 21, 2012 by Rhodes and Ochoa are consistent and are more credible than that of Respondent for the reasons set forth above.

23. Shortly after the May 21, 2012 surgery, Respondent created a form questionnaire which he asks a staff member to fill out after every surgical procedure he performs. The form contains boxes to be used in responding to questions relating to Respondent's ability to hear and communicate during the surgery, and whether he acted in any unusual way during the procedure. He asks only individuals who were present throughout the entire procedure to fill out the form. That individual then signs and dates the form. Since the form's inception, no one has provided any negative answers.

The Interview of May 31, 2012

24. The MEC at St. Joseph's Medical Center suspended Respondent's privileges immediately upon learning of the May 21, 2013 event, pending its receipt of medical clearance by Respondent's physicians. Respondent immediately scheduled appointments with his neurologist and psychiatrist for consultation and testing. He also continued his medical practice seeing patients in his office and performing surgeries in hospitals where his privileges were not suspended. On May 23, 2012, believing there had been either a misunderstanding or a conspiracy in the operating room (Respondent's testimony), Respondent wrote a letter to the MEC at St. Joseph's Medical Center explaining his version of the event of May 21, 2012 (Exhibit F).

25. On May 31, 2012, Respondent attended an interview with the MEC at St. Joseph's Medical Center. He was accompanied by his attorney, Tom Curtis.[2] At the administrative hearing, Respondent testified he believed the purpose of the interview was solely for him to establish that his physicians had medically cleared him to practice. Were this actually the case, it is difficult to understand why he felt the need to be represented by counsel, especially since the MEC had already received copies of Respondent's magnetic resonance imaging studies and written clearances from his physicians.

26. Respondent had slept very little the night before the interview.[3] At the interview, Respondent began with a lengthy narrative of the May 21, 2012 event. He drank water as he spoke. Approximately 30 minutes into the interview, by Respondent's estimate, Respondent suddenly became non-responsive to the committee members' questions concerning the incident. For example:

UNKNOWN: . . . Did you ask for any water during the case with a straw at all?

DR. EISENKOP: Right.

UNKNOWN: Did you?

DR. EISENKOP: Right.

MR. CURTIS: No, he wants to know if you asked for it during the case. Did you ask for water during the case?

DR. EISENKOP: Right.

MR. CURTIS: Did you?

DR. EISENKOP: Yes. I mean, anybody they can do, anybody can. Anybody can do that.

UNKNOWN: Did you drink?

DR. EISENKOP: Anybody can have a drink.

MR. CURTIS: Did you drink water during the case?

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[2] As indicated above, Mr. Curtis did not represent Respondent at the administrative hearing.

[3] He alternately stated during the interview that he had gone to bed at 2:30, that he had gone to bed at 3:00, that he had had "an emergency," and that people had been calling him during the night. (Exhibit 3.)

DR. EISENKOP: Yes. Anybody can do that.

UNKNOWN: Did you want to know why you were asked to step away?

DR. EISENKOP: I missed it perhaps.

UNKNOWN: Did you ask, did want (*sic*) to know why you were asked to step away from the patient?

DR. EISENKOP: I just figured, I guess.

UNKNOWN: Did you want to know why you were asked to step away from the patient?

DR. EISENKOP: I'm tired. What?

UNKNOWN: Did you want to know why you were asked to step away from the patient?

DR. EISENKOP: I'm so tired. I missed it. Huh?

MR. CURTIS: Let me say it to him.

UNKNOWN: Yeah. Why don't you tell him?

MR. CURTIS: Okay. During the case . . .

DR. EISENKOP: Yes.

MR. CURTIS: . . . the nurses asked you to step away.

DR. EISENKOP: Yes.

MR. CURTIS: Did you want to know why?

DR. EISENKOP: Yes.

MR. CURTIS: Did you ask?

DR. EISENKOP: Yes, I did. I'm very tired. I'm tired.

MR. CURTIS: Right now?

DR. EISENKOP: Yes.

UNKNOWN: Okay. Do you feel good? Are you okay?

DR. EISENKOP: Yes, just tired, very tired.

UNKNOWN: Are you having trouble hearing?

DR. EISENKOP: Yes, I'm just tired right now. Hold on.

UNKNOWN: Okay.

DR. EISENKOP: Okay. Now what did they say?

MR. CURTIS: When the nurses asked you to step away . . .

DR. EISENKOP: Yes.

MR. CURTIS: . . . did you ask why?

DR. EISENKOP: Yes. They could do it.

UNKNOWN: You . . .

DR. EISENKOP: What they said, I was very upset. Right.

MR. CURTIS: Okay. So did . . .

UNKNOWN: Why don't we take a break, yeah?

MR. CURTIS: Okay.

UNKNOWN: Go ahead.

UNKNOWN: He might want to take a walk outside.

MR. CURTIS: Sure. Scott, let's step outside for a while and take a break.

DR. EISENKOP: Yes. If it's okay, you bet.

MR. CURTIS: Okay. Let's take a little walk. Thank you.

DR. EISENKOP: No, I want to get it right.

MR. CURTIS: Now, we're gonna take a break and rest and then come back.

DR. EISENKOP: I feel, I feel so bad.

MR. CURTIS: It's okay, Scott.

DR. EISENKOP: Let me tell you something.

MR. CURTIS: Thanks very much, Greg.

DR. MESROBIAN: Oh, no, no.

DR. EISENKOP: (inaudible) take advantage. The problem is, I went to bed at 2:30 a.m. I didn't tell you that. And I went to bed at 3:00 a.m. I had an emergency. But can we continue, please?

UNKNOWN: Oh, sure.

DR. EISENKOP: Now who was next?

UNKNOWN: Did you want to know why Dr. Lin was called?

DR. EISENKOP: Yeah, but can you start over?

UNKNOWN: Yes. Did you want to know why Dr. Lin was called?

DR. EISENKOP: No. Could you start over?

UNKNOWN: He did.

UNKNOWN: Did you ask why Dr. Lin was called?

DR. EISENKOP: No, tell me why?

UNKONWN: I'm asking you. Did you want to know?

DR. EISENKOP: Start over again, please.

UNKNOWN: Did you want to know why Dr. Lin was called that night?

DR. EISENKOP: No. Can you tell me again? Start over.
(Exhibit 3, pages 10-14.)

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27. At the administrative hearing, Respondent admitted that some of his answers to the questions during the May 31, 2012 interview were not responsive. However, he explained that he had a very discordant relationship with most of the committee members, and that his attorney had advised him to keep his answers short and to avoid saying anything that could be construed as negative.[4] Because he therefore had to contemplate the answers to the questions instead of answering as he wanted to, he used his non-responsive answers as a way to "buy time" (Respondent's term) in order to search for appropriate answers to the questions. In addition, the committee member who asked him the question regarding whether he drank water during the surgery had asked him a similar question in another proceeding, and Respondent was both offended and humiliated to have to answer it again.

28. That explanation was not credible. First, even if his attorney had given Respondent the advice Respondent claims, the same attorney seemed as puzzled by the answers as the committee members were. In fact, Respondent's attorney asked Respondent the very same questions the committee members did, and attempted to assist the committee members in obtaining the answers to their questions. When that failed to elicit responsive answers, Respondent's attorney attempted to take Respondent on a break. Secondly, the questions concerning whether he drank water during the surgery, whether he wanted to know why he was asked to step away from the operating table, and whether he wanted to know why Dr. Lin was called, all could be answered with "yes" or "no" without any negative connotation or lengthy narrative. Third, Respondent's non-responsiveness was not an attempt to "buy time" to find an answer that would be short in compliance with his attorney's advice. He had already disregarded his attorney's advice by engaging in a long narrative concerning the events of May 21. Fourth, Respondent did not "buy time" to develop an appropriate answer. He failed to answer responsively at all. Finally, Respondent's claim of extreme fatigue was not convincing in that it was inconsistent with his penchant for working extremely long hours on very little rest. Respondent claims he used fatigue as a method of delay to frame appropriate answers to the questions. However, that claim is inconsistent with his resistance to taking a break and wanting to continue with the interview.

29. Following the May 31, 2012 interview, the MEC of St. Joseph's Medical Center left Respondent's suspension of privileges in place. Respondent has not worked at that hospital since May 21, 2012.

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[4] Respondent waived the attorney-client privilege in that regard.

Privileges at Providence Tarzana Medical Center

30. Providence Tarzana Medical Center also suspended Respondent's privileges after the May 21, 2012 incident at St. Joseph's Medical Center and, in connection with that suspension, Respondent was referred to Donald Sutherling, M.D. for evaluation. Dr. Sutherling performed a number of video EEG's on Respondent. On June 11, 2012, the EEG was abnormal, showing multiple bilateral anterial temporal spikes on the left which awakened him from sleep but without confusion upon awakening. Dr. Sutherling interpreted those spikes as a partial seizure disorder. Video EEG's on July 17, 2012 and August 21, 2012 resulted in a modification of his medication dosages. The July 17, 2012 EEG showed the same kinds of spikes as did the June 11, 2012 EEG, and possibly right side spikes as well. The condition was improved on August 21, 2012 following the medication adjustment. Dr. Sutherling opined that Respondent needed to restrict the number of hours he worked in order to minimize the risk of seizures.

31. On November 11, 2012, Respondent entered into an agreement with the MEC at Providence Tarzana Medical Center[5] according to which his privileges were restored subject to the following terms and conditions:

> 1, Have EEGs in accordance with Dr. Sutherling's recommendations. The EEGs can be performed by Dr. Kowell, if you wish.
>
> 2. If the EEGs are performed by Dr. Kowell or someone other than Dr. Sutherling, sign an authorization and release for that physician to send the EEG and information to Dr. Sutherling (or another physician who may be selected by the MEC) for his review.
>
> 3. Sign an authorization and release for Dr. Sutherling (or another physician who may be selected by the MEC) to communicate with the Medical Staff regarding your condition as it may affect your ability to safely practice.
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> 4. Limit the total of your office hours and surgery hours to 50 hours per week.

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[5] Respondent also claimed a "stressful and negative" relationship with the MEC at Providence Tarzana Medical Center due to "politics and competition." (Respondent's terms.)

5. Not schedule surgical cases at Providence Tarzana Medical Center to commence after 2 pm. If you are not available to start your scheduled case until after 2 pm, the case will be cancelled and may be rescheduled. If there is an emergency case and you determine it would be unsafe to postpone the case until the next morning, you may proceed with the emergency case. However, within 24 hours of completing the surgery, you must notify the Surgery Department Chair in writing of the case, why it was an emergency, and why it would have put the patient at unavoidable risk to delay the case until the next morning.

6. Establish and comply with a call arrangement with another GYN/Oncologist so that you are not on call all of the time, but share equally coverage with the other GYN/Oncologist. You will provide the Medical Staff the name of the GYN/Oncologist with whom you are sharing call coverage. (This is not to limit you from establishing call with more than one other GYN/Oncologist, provided you do not take more than 50% of the call.)

7. Use a surgeon as your assistant in all laparotomy and laparoscopic procedures at Providence Tarzana Medical Center.

8. On a weekly basis, submit to the Medical Staff Office your office schedule, your surgery schedule (to include all surgeries in which you are present, including all facilities) and sleep log (to include total of the hours per day, not the specific times). The MECs designee will review the materials to verify that the total reported office hours and time expected for the reported surgeries should not have exceeded 50 hours per week and that you are averaging at least 7 hours of sleep a night. If the Medical Staff has questions, you will promptly provide the requested information within 72 hours of receipt of the request. You are responsible for assuring these materials and all requested information are timely delivered to the Medical Staff Office with a receipted delivery. Should the materials or information not be timely received, you must promptly provide the tracking number and tracking information to the Medical Staff.

(Exhibit 4.)

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32. Respondent signed the agreement under language stating in part: "I agree that the restrictions and monitoring described in this letter are reasonable and warranted and that I will comply with each of the requirements." (*Id.*) However, at the administrative hearing, he denied that the terms and conditions imposed by Providence Tarzana Medical Center were either reasonable or warranted, and he claimed that the restrictions placed on his surgery time were "irrelevant and arbitrary." (Respondent's terms.) Respondent explained that it serves no purpose to limit his working hours because working hours can be defined in various ways. For example, depending on how a surgery is defined, the same procedure can have lasted three hours or ten hours. Respondent believes the condition imposed by the MEC is therefore irrelevant to whether he gets sufficient rest.

The Experts

33. Complainant offered the expert testimony of retired neurologist, Kannen Paramesh, M.D. Dr. Paramesh retired from the practice of medicine in October 2013. He examined Respondent in February 2013. Dr. Paramesh's recent retirement does not impact on his competence to render expert opinions in this case.

34. Respondent offered the expert testimony of neurologists, Loren Label, M.D., Harris Fisk, M.D., and Arthur Kowell, M.D. (Respondent's treating neurologist), and psychiatrist, Brian Jacks, M.D. Each of those physicians was well qualified to offer expert opinions.

35. All of the experts agreed that Respondent suffers from a seizure disorder borne of changes in the brain as a result of his 1996 cancer treatment. There is some variance of opinion as to whether any of his seizures have been complex partial seizures as opposed to simple partial seizures, with those hired by Respondent favoring the latter, and Dr. Paramesh claiming the former in his report, but only acknowledging the possibility in his testimony. The consensus among the experts is that Respondent's seizure disorder is manifested by speech arrest. All of the experts agree that lack of sleep increases the risk of seizures and that, to minimize the risk, Respondent must maintain compliance with a strict regimen of medication prescribed at therapeutic levels, and he must get adequate rest.

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36. Dr. Paramesh opined that Respondent suffered a simple partial psychic seizure during the surgery of May 21, 2012. Psychic seizures are marked by confusion, garbled speech, an inability to find the correct words to communicate, memory loss, and an unawareness of conscious state. Dr. Kowell acknowledged that possibility but with the caveat that Respondent has a speech impediment that can be misinterpreted. Dr. Jacks also acknowledged the possibility of a simple partial seizure but found no evidence of one because Respondent showed no automatic uncontrolled movements consistent with such seizures. He also opined that simple partial seizures do not interfere with an individual's ability to function.[6]

37. Dr. Paramesh found the episode of May 31, 2012 suspicious of seizure, but he was unable to opine as to whether it was of the complex or simple type.

38. Dr. Fisk acknowledged the possibility of a seizure on May 31, 2012, but opined that it was more likely stress-related due to confusion because Respondent's answers were challenged. A review of the transcript and/or recording of the interview reveals that Respondent's answers were not being challenged. The questioners, including his own attorney, were simply attempting to understand what Respondent was saying.

39. Dr. Kowell offered several theories for what occurred on May 31, 2012 including fatigue and stress from sleep deprivation, anxiety, depersonalization, and fugue state. He also acknowledged the possibility that Respondent may have suffered a seizure. There is no evidence that Respondent has ever suffered from depersonalization disorder or fugue. The theory that he was stressed and anxious was undermined by his affect during his testimony at the administrative hearing in which he appeared relaxed and confident.

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[6] No other experts referred to such uncontrolled movements as indicative of a simple partial seizure, and the remainder of the experts found the only manifestation of Respondent's simple partial seizures to be speech arrest. Dr. Jacks' opinion that simple partial seizures do not interfere with an individual's ability to function is undermined by Respondent's inability to form words during a seizure, an essential form of communication for a surgeon. Dr. Jacks' opinion on this subject is given little weight.

40. Dr. Jacks testified that Respondent did not suffer a seizure on May 31, 2012. Rather, his non-responsive actions were a function of fatigue, stress, his obsessive/compulsiveness, his need to be in control, and an inability to communicate well with other people. Respondent's dry mouth interfered with his communication. When questioned near the end of his testimony as to why the episode occurred in the middle of the interview rather than at the beginning, Dr. Jacks opined that it was a function of Respondent being passive-aggressive toward the interviewers, and that the passive-aggressiveness stemmed from his stress response based on his personality. Dr. Jacks' testimony was not credible. He had conducted a psychiatric evaluation on Respondent which included administration of the Minnesota Multiphasic Personality Inventory-2 (MMPI-II), and a three-hour interview. His primary diagnosis was adjustment disorder with mixed emotional features and obsessive/compulsive personality features. At no time earlier in his testimony did he ever mention passive/aggressive behavior. He did not testify that he found any indication of passive/aggressiveness in Respondent during their interview, or that passive/aggressive behavior was noted on the results of the MMPI-II. He did not diagnose passive/aggressive personality disorder, traits, or even features. Similarly, his diagnosis is devoid of any mention of stress disorder or stress-related traits or features.

41. None of Respondent's experts explained how their theories of what occurred on May 31, 2012 reconciled with the fact that the episode occurred in the middle of the interview as opposed to near the beginning when stress and anxiety would normally be higher.

LEGAL CONCLUSIONS

1. Cause exists to suspend or revoke Respondent's certificate, pursuant to Business and Professions Code section 822, for having a physical illness affecting competency, as set forth in Findings 5 through 41.

2. The standard of proof applicable to this case is clear and convincing evidence to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) This means the burden rests on Complainant to establish the charging allegations by proof that is clear, explicit and unequivocal--so clear as to leave no substantial doubt, and sufficiently strong to command the unhesitating assent of every reasonable mind. (*In re Marriage of Weaver* (1990) 224 Cal.App.3d 478.) "Evidence of a charge is clear and convincing so long as there is a 'high probability' that the charge is true. [Citations.] The evidence need not establish the fact beyond a reasonable doubt." (*Broadman v. Comm'n on Judicial Performance* (1998) 18 Cal.4th 1079, 1090.)

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3. Business and Professions Code section 822 states:

If a licensing agency determines that its licentiate's ability to practice his or her profession safely is impaired because the licentiate is mentally ill, or physically ill affecting competency, the licensing agency may take action by any one of the following methods:

(a) Revoking the licentiate's certificate or license.

(b) Suspending the licentiate's right to practice.

(c) Placing the licentiate on probation.

(d) Taking such other action in relation to the licentiate as the licensing agency in its discretion deems proper.

The licensing agency shall not reinstate a revoked or suspended certificate or license until it has received competent evidence of the absence or control of the condition which caused its action and until it is satisfied that with due regard for the public health and safety the person's right to practice his or her profession may be safely reinstated.

4. The trier of fact may reject the testimony of a witness, including an expert witness, even if it is uncontradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) The trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected available material." (*Id.* at 67-68.)

5. Complainant correctly argued that she does not have to prove Respondent suffered either a complex partial seizure or a simple complex seizure on May 21 or May 31, 2012. She need only prove the elements in Business and Professions Code section 822. Respondent has a history of a seizure disorder that has manifested on a number of occasions. Seizure activity was demonstrated on the EEG temporally closest to the two dates involved with this case. Dr. Sutherling found the spikes recorded on the EEG highly correlated to a seizure disorder.

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6. Respondent experienced two unusual occurrences in May 2012. The first one occurred during surgery and manifested in his inability to speak to the operative staff for between 10 and15 minutes. This not only placed his patient at risk, a potential inability of a lead surgeon to communicate with his staff for 10 to 15 minutes places at risk every patient on whom the surgeon operates. Although Respondent has a set of hand signals for use with staff members he knows very well, the evidence showed he also works with individuals he does not know well. Accordingly, Respondent cannot, and does not, rely on hand signals in every surgical procedure. Nor does the questionnaire Respondent created for completion by surgical staff members solve the problem. Those questionnaires show what happened (or didn't) during a given surgery. However, they do not address the potential risk of Respondent suffering a seizure while operating. A negative questionnaire will do no good if a patient is harmed because Respondent suffered a seizure during surgery.

7. For the reasons set forth above, Respondent's version of the events of May 21, 2012 was not convincing. Although he claims to have been the victim of a misunderstanding or a conspiracy, neither was established by the evidence.

8. The second occurrence took place 10 days later, on May 31. Although Respondent's experts attribute that occurrence variously to stress, nervousness, fatigue, passive-aggressive behavior and the like, Respondent has no history of any such conditions. However, he does have a history of a seizure disorder. Further, Respondent failed to account for the fact that he had no difficulty speaking at great length during the first portion of the interview with the MEC of St. Joseph's Medical Center, but suddenly became confused and non-responsive well into the interview, being unable to answer a simple question as to whether he consumed water during the May 21, 2012 surgery with the word "no."

9. Had Respondent become non-responsive on May 31, 2012 due to fear of losing his hospital privileges, as was suggested during the hearing, that fearfulness should have been at least as strong, if not stronger, at the administrative hearing, where his license to practice medicine, rather than his hospital privileges, was at risk. However, during the administrative hearing, he was calm, confident, and focused, and he was able to articulate his words in such a way that it was not difficult to understand him.

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10. Business and Professions Code section 2229 states:

(a) Protection of the public shall be the highest priority for the Division of Medical Quality, the California Board of Podiatric Medicine, and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority.

(b) In exercising his or her disciplinary authority an administrative law judge of the Medical Quality Hearing Panel, the division, or the California Board of Podiatric Medicine, shall, wherever possible, take action that is calculated to aid in the rehabilitation of the licensee, or where, due to a lack of continuing education or other reasons, restriction on scope of practice is indicated, **to order restrictions as are indicated by the evidence.**

(c) It is the intent of the Legislature that the division, the California Board of Podiatric Medicine, and the enforcement program shall seek out those licensees who have demonstrated deficiencies in competency and then take those actions as are indicated, with priority given to those measures, including further education, restrictions from practice, or other means, that will remove those deficiencies. **Where rehabilitation and protection are inconsistent, protection shall be paramount.** (Emphasis added.)

11. This does not mean that Respondent's certificate must be revoked because he might suffer a simple partial seizure while at work. In fact, Complainant did not request license revocation. She contends, and the Administrative Law Judge concurs, that a period of properly-conditioned probation should adequately protect the public's health, safety, welfare, and interest. Respondent argues that this is unnecessary because he is under the care of a neurologist who treats his seizure disorder with appropriate medication and periodically checks his serum levels. Respondent further claims he does, and will, get adequate rest. For the reasons set forth below, those claims are inadequate to enable Respondent to forgo Board supervision.

12. The experts agreed that the risk of seizure can be minimized by maintaining an appropriate medication regimen at therapeutic dosages as determined by periodic blood tests, by Respondent remaining in compliance with his medication regimen, and by Respondent getting adequate rest. However, Respondent prides himself on his work ethic. He works long hours taking on as many referrals as he can, even when it means working long into the night. Although he testified at the administrative hearing that he averages approximately seven hours of sleep per night, he took on a somewhat defiant attitude toward the "rest requirement" in the agreement with the MEC at Providence Tarzana Medical Center that restored his privileges at that hospital, claiming that it was "irrelevant and arbitrary," and he demonstrated ways to "get around" its constraints.

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13. Accordingly, the Board cannot count on Respondent to ensure his own adequate rest and compliance with his neurologist's orders. The evidence established that Respondent is a strong-willed individual who insists on being in control of what is occurring in his life, be it the personnel comprising the staff with whom he works in the operating room, hospital management personnel, or his own personal well-being such as determining the ratio of patient care to sleep he is willing to maintain. The only way to ensure Respondent's continued work without increasing the risk of seizures through medication non-compliance and/or inadequate rest is through Board supervision. Respondent's belief that he will remain compliant and rested is laudable but unenforceable. Respondent believes his duty is to his patients. The Board's duty is to the public. The two are not mutually exclusive, but they are different.

14. Respondent also argued that, despite his seizure disorder, the California Department of Motor Vehicles (DMV) permits him, and other individuals with simple partial seizure disorders, to drive. He reasons that, since having a seizure while driving a motor vehicle has the potential of causing great personal injury and property damage, it follows that, if he can be permitted to drive without restriction, he should be able to perform surgery without restriction. Although, on its face, this is an interesting argument, it is not persuasive. First, Respondent did not offer into evidence the standards DMV uses in determining whether an individual with a seizure disorder is permitted to maintain his/her driving privilege. The standard used by that agency may not match that used by the Board. Secondly, if DMV builds in a margin of error such that it is willing to risk bodily injury and property damage, the Board is not required to follow suit. Finally, the manifestation of Respondent's disorder, specifically speech arrest, does not disqualify him from driving. He does not need his voice or his ability to form verbal words while he drives, but his voice and his ability to form verbal words are essential during surgery.

15. Respondent argued that his surgical skills are so extraordinary that the loss of his availability to practice without restriction would have a calamitous effect on the medical community he serves, and he offered the testimony of various health care professionals to corroborate that claim. No one on either side challenged or disputed the quality of Respondent's surgical skills. However, those skills must be used judiciously by ensuring that Respondent minimizes his risk of intra-operative seizure by compliance with his medication regimen, periodic blood tests to ensure therapeutic dosages, and adequate rest. To the extent that only a limited number of gynecological oncologists practice in Respondent's geographic area, Respondent acknowledged that more physicians are entering the field regularly. Further, the medical community is not being entirely deprived of Respondent's skills. Respondent is only being limited in a manner that will maximize patient safety. His patients will still have access to his skills, albeit not at all hours. Because most of his cases are non-emergent, and because emergent cases are excluded from the Order in this case, patient inconvenience should be minimized. Because he will be required to properly maintain his medication regimen and receive adequate rest, patient safety will be maximized.

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16. Complainant argued that one of the terms of probation should be the inclusion of a practice monitor. It is unclear what a practice monitor could accomplish in this case. This is not a matter of proper patient care, proper billing, or adequate and accurate record keeping. It is solely a matter of Respondent minimizing his risk of seizure. The onus for that falls entirely on Respondent. However, to ensure patient safety, an assistant surgeon, capable of assuming Respondent's duties, must be present for the duration of each surgical procedure Respondent performs during the probationary period.

17. During the administrative hearing, Complainant also took the position that Respondent should be required to undergo periodic EEG's. The evidence adduced during the hearing showed that such tests were unnecessary on a regular basis, and Complainant withdrew from that position.

18. Respondent has faced and overcome numerous difficulties since contracting cancer in 1996. In so doing, he has had to make multiple adjustments to the way he lives and the way he practices medicine. The imposition of probation to ensure public safety is one more such adjustment that Respondent must make to continue the high quality of patient care for which he is known. In order to ensure he is practicing as safely as possible under the circumstances, he must be subject not only to the Board's standard terms and conditions of probation, but also to custom terms and conditions including continued medical evaluation and treatment, ongoing blood testing, limitation of working hours, and the use of an assistant surgeon in all surgical procedures. Because his seizure disorder is likely to continue for the rest of his life, a lengthy term of probation is required.

19. For the most part, the Board's model terms (Medical Board of California Manual of Model Disciplinary Orders and Disciplinary Guidelines, 11th ed. 2011) are followed in the Order below. Some of the terms and conditions of probation are "custom" terms written pursuant to Business and Professions Code sections 822, subdivision (d) and 2229, subdivision (b). For those terms and conditions, the Board's model terms are used for guidance and as models. For example, Condition No. 1 in the Order is based in part on Model Term No. 22, and Condition No. 2 is based in part on Model Term No. 11.

ORDER

Certificate No. G 41053 issued to Respondent, Scott Eisenkop, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for ten years upon the following terms and conditions.

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1. Medical Evaluation and Treatment

Within 30 calendar days of the effective date of this Decision, and no fewer than every six months thereafter as may be required by the Board or its designee, Respondent shall undergo a medical evaluation by a Board-appointed physician who shall consider any information provided by the Board or designee and any other information the evaluating physician deems relevant and shall furnish a medical report to the Board or its designee. Respondent shall provide the evaluating physician any information and documentation that the evaluating physician may deem pertinent.

Following the evaluation, Respondent shall comply with all restrictions or conditions recommended by the evaluating physician within 15 calendar days after being notified by the Board or its designee. If Respondent is required by the Board or its designee to undergo medical treatment, Respondent shall, within 30 calendar days of the requirement notice, submit to the Board or its designee for prior approval the name and qualifications of a California licensed treating physician of Respondent's choice. Upon approval of the treating physician, Respondent shall, within 15 calendar days, undertake medical treatment and shall continue such treatment until further notice from the Board or its designee.

The treating physician shall consider any information provided by the Board or its designee or any other information the treating physician may deem pertinent prior to commencement of treatment. Respondent shall have the treating physician submit quarterly reports to the Board or its designee indicating whether or not Respondent is capable of practicing medicine safely. Respondent shall provide the Board or its designee with any and all medical records pertaining to treatment, the Board or its designee deems necessary.

If, prior to the completion of probation, Respondent is found to be physically incapable of resuming the practice of medicine without restrictions, the Board shall retain continuing jurisdiction over Respondent's license and the period of probation shall be extended until the Board determines that Respondent is physically capable of resuming the practice of medicine without restrictions. Respondent shall pay the cost of the medical evaluation(s) and treatment.

Respondent shall not engage in the practice of medicine until notified in writing by the Board or its designee of its determination that Respondent is medically fit to practice safely.

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2. Blood Testing

Within 30 calendar days of the effective date of this Decision, and no less than every six months thereafter, Respondent shall undergo testing of his blood to ensure medication he is taking for seizure disorder is maintained at therapeutic levels. Prior to practicing medicine, Respondent shall contract with a laboratory or service approved in advance by the Board or its designee that will conduct the blood testing. The contract shall require results of the tests to be transmitted by the laboratory or service directly to the Board or its designee within four hours of the results becoming available. Respondent shall maintain this laboratory or service contract during the period of probation. Respondent shall be responsible for all costs connected with this probationary term.

A certified copy of any laboratory test result may be received in evidence in any proceedings between the Board and Respondent.

The failure of Respondent to comply with this condition shall be considered a violation of probation.

3. Limitation on Work-Related Hours

Respondent shall limit his work-related hours to periods of no more than 10 consecutive hours. "Work-related hours" are defined as those hours in which Respondent is performing any of the duties of a physician and surgeon including but not limited to performing surgery, assisting in surgical procedures, time spent between a surgery's scheduled start time and its actual start time, giving other medical treatment, consultation with patients, other physicians, and other medical personnel, patient examination, travel to and from office and hospitals for patient care, chart and/or report writing, teaching, and medical research. The cessation of any consecutive work-related hours, even if fewer than 10 consecutive hours, shall be followed by no fewer than nine consecutive hours spent in activities other than performing the duties of a physician and surgeon. This condition is intended to ensure Respondent receives adequate rest so as to minimize the risk of seizures during work-related hours.

Respondent shall not schedule any surgeries or other work-related activities in a manner that may risk his having to perform work-related activities following the 10 consecutive hour allotment.

This condition of probation shall not apply to emergent cases. However, within 24 hours of completion of any such emergent surgery, Respondent shall notify the Board or its designee that he performed an emergent procedure following the expiration of the 10 consecutive hour work-related allotment, the nature of the case, why Respondent considered the case emergent, and why he believed the procedure could not have been performed on an urgent basis within a 10 consecutive hour work-related allotment without placing the patient at undue risk.

Any emergent procedure that requires Respondent to engage in work-related activities beyond the 10 consecutive hour work-related allotment shall be followed by no fewer than nine consecutive hours of non-work-related time.

Respondent shall maintain a monthly log including, at minimum, the date, the beginning and ending times of consecutive hours spent in work-related activities, the beginning and ending times of consecutive hours spent in non-work-related activities, and the beginning and ending times in excess of the 10 consecutive hour allotment while he was engaged in an emergent case(s). Respondent shall provide to the Board or its designee a copy of each monthly log within 10 days of the end of the month covered by that log.

The failure of Respondent to comply with all aspects of this condition shall be considered a violation of probation.

4. Utilization of Assistant Surgeon During Surgeries

On each and every case in which Respondent serves as the primary surgeon, regardless of the case's nature and/or requirements, Respondent shall utilize the services of an assistant surgeon who is qualified and capable of assuming the duties and responsibilities of the primary surgeon. Another gynecological oncologist, qualified gynecologist, or general surgeon shall qualify for this purpose. The assistant surgeon shall be present throughout the course of the surgical procedure. Respondent shall not utilize the services of a registered nurse first assistant in place of an assistant surgeon on any such case.

5. Notification

Within seven days of the effective date of this Decision, Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

6. Supervision of Physician Assistants

During probation, Respondent is prohibited from supervising physician assistants.

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7. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

8. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

9. General Probation Requirements

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

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Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

10. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

11. Non-Practice While on Probation

Respondent shall notify the Board or its designee, in writing, within 15 calendar days, of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

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12. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

13. License Surrender

Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall, within 15 calendar days, deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

14. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

15. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

Dated: May 7, 2014

H. Stuart Waxman

H. STUART WAXMAN
Administrative Law Judge
Office of Administrative Hearings

Exhibit B

Decision Following Remand In the Matter of the Accusation Against:
Scott Eisenkop, M.D.," Case No. 17-2012-224090, effective May 17, 2016

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
SCOTT EISENKOP, M.D.	)	Case No. 17-2012-224090
Physician's and Surgeon's Certificate No. G41053	)	
Respondent	)	

DECISION

The attached Proposed Stipulated Decision and Order After Remand is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on June 16, 2016.

IT IS SO ORDERED May 17, 2016.

MEDICAL BOARD OF CALIFORNIA

By: _____
Jamie Wright, J.D., Chair
Panel A

KAMALA D. HARRIS
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
COLLEEN M. MCGURRIN
Deputy Attorney General
State Bar Number 147250
300 South Spring Street, Suite 1702
Los Angeles, California 90013
Telephone: (213) 620-2511
Facsimile: (213) 897-9395
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: SCOTT EISENKOP, M.D. 24236 Long Valley Road Hidden Hills, California 91302 Physician's and Surgeon's Certificate G-41053, Respondent.	Case No. 17-2012-224090 OAH No. 2013060333 **PROPOSED STIPULATED DECISION AND ORDER AFTER REMAND**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") is the Executive Director of the Medical Board of California ("Board"). She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Colleen M. McGurrin, Deputy Attorney General.

2. Respondent Scott Eisenkop, M.D. ("Respondent") is represented in this proceeding by attorney Benjamin J. Fenton of the Fenton law Group, LLP, 1990 South Bundy Drive, Suite 777, Los Angeles, California 90025.

3. On October 15, 1979, the Board issued Physician's and Surgeon's Certificate number G-41053 to Respondent. That license was in full force and effect at all times relevant to the charges brought in Accusation No. 17-2012-224090, and will expire on March 31, 2017, unless renewed.

JURISDICTION

4. Accusation No. 17-2012-224090 was filed before the Board against Respondent on May 22, 2013. The Accusation and all other statutorily required documents were properly served on Respondent. Respondent filed a timely Notice of Defense contesting the Accusation.

5. Commencing on April 21, 2014, and concluding April 25, 2014, a hearing was held before the Administrative Law Judge H. Stuart Waxman on the charges in Accusation No. 17-2012-224090.

6. On June 9, 2014, the Board adopted the proposed Decision and made it effective on July 9, 2014.

7. On July 1, 2014, Respondent filed a Petition for Reconsideration of the Board's Decision and Order.

8. On July 3, 2014, the Board issued a stay order extending the effective date of the Decision and Order to July 18, 2014.

9. On July 14, 2014, the Board issued an Order Denying Respondent's Petition for Reconsideration.

10. On July 18, 2014, Respondent filed a Petition for Writ of Administrative Mandamus in the Los Angeles Superior Court under case number BS 149900.

11. On April 14, 2015, Respondent's writ was heard before Judge James C. Chalfant, in Department 85 of the Los Angeles Superior Court.

12. On May 14, 2015, Judge Chalfant signed a Judgment Denying in Part and Granting in Part Administrative Writ of Mandamus whose effect was to remand this matter back to the Board to either delete, modify with Petitioner's (Respondent's) consent, or to take further evidence concerning two provisions of the earlier decision: first, the definition of "work-related hours" defined in Condition 3, Limitation of Work-Related Hours; and second, to either delete, modify

with Petitioner's (Respondent's) consent, or take further evidence regarding Condition 4, Utilization of Assistant Surgeon During Surgeries.

13. A copy of the Board's Order of Remand to Administrative Law Judge, which includes the original proposed decision and the Superior Court's judgment and decision on the administrative writ, is attached as Exhibit A and is incorporated herein by reference.

ADVISEMENT AND WAIVERS

14. Respondent has carefully read, fully discussed with counsel, and understands the Order of Remand to Administrative Law Judge Case No. 17-2012-224090, pursuant to the Superior Court's ruling. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Proposed Stipulated Decision and Order after Remand.

15. Respondent is fully aware of his legal rights in this matter, including the right to a remand hearing on the definition of "work-related hours" as defined in Conditions 3 of the Disciplinary Order, and Condition 4, utilization of assistant surgeon during surgeries; the right to be represented by counsel at his own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

16. Respondent freely, voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

17. At a hearing on the charges and allegations contained in Accusation No. 17-2012-224090, which commenced April 21, 2014, and concluded April 24, 2014, Administrative Law Judge, H. Stuart Waxman found that cause exists for imposing discipline upon Respondent's Physician's and Surgeon's Certificate for having a physical illness affecting his competency pursuant to Business and Professions Code section 822. In his proposed decision, dated May 7, 2014, Administrative Law Judge Waxman ordered that Respondent be placed on probation for 10 years on various terms and conditions. Said proposed decision was adopted by the Board as its

Decision and Order, and was effective, after the Board denied Respondent's Petition for Reconsideration, on July 18, 2014.

18. Thereafter, Respondent filed an Administrative Writ of Mandamus in the Superior Court. Said writ was denied in part and granted in part, and the matter was remanded to the Board to either: delete, modify with Petitioner's (Respondent) consent, or hold a hearing to take further evidence concerning the definition of "work-related hours" defined in Condition 3; and delete, modify with Petitioner's (Respondent) consent, or hold a hearing to take further evidence concerning Condition 4, Utilization of Assistant Surgeon in Surgeries. All other provisions, terms and conditions of the Board's Decision and Order were upheld by the Superior Court.

For the purpose of resolving the Order of Remand without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant established a factual basis for the charges in the Accusation No. 17-2012-224090, and that those findings have been upheld on appeal.

19. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

20. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this proposed Stipulated Decision and Order after Remand, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Decision and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

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21. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Decision and Order after Remand, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

22. In consideration of the foregoing stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED THAT Physician's and Surgeon's Certificate No. G41053 issued to Respondent, Scott Eisenkop, M.D., is subject to the Board's prior Disciplinary Order Case No. 17-2012-224090, dated June 9, 2014, and made effective July 18, 2014; however, Conditions 3 and 4 thereof are hereby modified pursuant to the Superior Court's judgment, dated May 14, 2015, as follows: All other terms and conditions of the Board's prior Disciplinary Order remain in full force and effect as specified in Attachment A.

3. LIMITATION OF WORK-RELATED HOURS. Respondent shall limit his work-related hours to periods of no more than 10 consecutive hours. "Work-related hours" is modified to define those hours in which Respondent is performing any of the duties of a physician and surgeon including but not limited to performing surgery, assisting in surgical procedures, giving other medical treatment, consultation with patients, other-physicians, and other medical personnel, patient examination, travel to and from office and hospitals for patient care, chart and/or report writing, teaching, and medical research. Time spent in between "work-related hours" in which Respondent is not engaged in work-related activities and the time waiting for a surgery to commence, shall not be considered "work-related hours" unless that time exceeds three hours, individually or collectively if multiple surgeries are scheduled the same day.

The cessation of any consecutive work-related hours, even if fewer than 10 consecutive hours, shall be followed by no fewer than nine consecutive hours spent in activities other than performing the duties of a physician and surgeon. This condition is intended to ensure Respondent receives adequate rest so as to minimize the risk of seizures during work-related hours.

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Respondent shall not schedule any surgeries or other work-related activities in a manner that may risk his having to perform work-related activities following the 10 consecutive hour allotment. This condition of probation shall not apply to emergent cases. However, within 24 hours of completion of any such emergent surgery, Respondent shall notify the Board or its designee that he performed an emergent procedure following the expiration of the 10 consecutive hour work-related allotment, the nature of the case, why Respondent considered the case emergent, and why he believed the procedure could not have been performed on an urgent basis within a 10 consecutive hour work-related allotment without placing the patient at undue risk. Any emergent procedure that requires Respondent to engage in work-related activities beyond the 10 consecutive hour work-related allotment shall be followed by no fewer than nine consecutive hours of non-work-related time.

Respondent shall maintain a monthly log including, at minimum, the date, the beginning and ending times of consecutive hours spent in work-related activities, the beginning and ending times of consecutive hours spent in non-work-related activities, and the beginning and ending times in excess of the 10 consecutive hour allotment while he was engaged in an emergent case(s). Respondent shall provide to the Board or its designee a copy of each monthly log within 10 days of the end of the' month covered by that log.

The failure of Respondent to comply with all aspects of this condition shall be considered a violation of probation.

4. UTILIZATION OF ASSISTANT SURGEON OR REGISTERED NURSE FIRST ASSISTANT DURING SURGERIES AND HAVE ANOTHER SURGEON ON-CALL.

On each and every case in which Respondent serves as the primary surgeon, regardless of the case's nature and/or requirements, Respondent shall utilize the services of an assistant surgeon (gynecological oncologist, qualified OB/GYN, or general surgeon) or a registered nurse first assistant (RNFA) who shall be present throughout the course of the surgical procedure unless a staff change is necessary due to the length of the procedure. Additionally, Respondent shall have another surgeon on-call and available to arrive on the premises within 30 minutes to safely take over and complete, conclude, and/or terminate and close any of Respondent's procedures, if

necessary.

ACCEPTANCE

I have carefully read the above proposed Stipulated Decision and Order after Remand and have fully discussed it with my attorney, Benjamin J. Fenton. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Decision and Order after Remand freely, voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 2/10/16

SCOTT EISENKOP, M.D.
Respondent

I have read and fully discussed with Respondent Scott Eisenkop, M.D. the terms and conditions and other matters contained in the above Stipulated Decision and Order After Remand. I approve its form and content.

DATED: 2/10/16

BENJAMIN J. FENTON
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Decision and Order after Remand is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: 2/12/2016

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

COLLEEN M. MCGURRIN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Order of Remand to Administrative Law Judge No. 17-2012-224090

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
Scott Eisenkop, M.D.	Case No. 17-2012-224090
Physician's and Surgeon's Certificate No. G 44814	OAH No. 2013060333
Respondent.	

ORDER OF REMAND TO ADMINISTRATIVE LAW JUDGE

Pursuant to the provisions of subdivision (c) of section 11517 of the Government Code, Panel A of the Medical Board of California hereby remands the attached Proposed Decision (Decision) to Administrative Law Judge H. Stuart Waxman for rehearing, including the taking of evidence consistent with the order of the Los Angeles Superior Court dated May 7, 2014, a copy of which is attached.

IT IS SO ORDERED this 11th day of August, 2015.

MEDICAL BOARD OF CALIFORNIA

Jamie Wright, J.D., Chair
Panel A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: SCOTT EISENKOP, M.D., Physician's and Surgeon's Certificate No. G 41053, Respondent.	Case No. 17-2012-224090 OAH No. 2013060333 **ORDER RE: REMAND PURSUANT TO GOVERNMENT CODE SECTION 11517(c)(2)(D)**

On August 11, 2015 the Medical Board of California (Board) filed an order remanding the above-captioned case to administrative law judge (ALJ) H. Stuart Waxman for the purpose of taking additional evidence pursuant to California Government Code section 11517, subdivision (c), following the issuance of a Judgment Denying in Part and Granting in Part Administrative Writ of Mandamus with respect to the Board's final decision dated June 9, 2014, in this matter. However, the Board failed to provide the transcripts and exhibits of the entire prior proceedings, and the Board likewise failed to provide the final decision of the Medical Board of California dated June 9, 2014, from which the Judgment Denying in Part and Granting in Part Administrative Writ of Mandamus issued. Because only the Proposed Decision was remanded, and the Board's final decision was not made part of the record, it is unclear whether the probationary terms as to which additional evidence is to be received and considered pursuant to the Judgment Denying in Part and Granting in Part Administrative Writ of Mandamus are the same probationary terms set forth in the Proposed Decision; the final decision must be a part of the record to ensure that the Board did not make any changes to the referenced portions of the Proposed Decision in the Board's June 9, 2014 final decision.

The following order is issued with respect to the remand in this case:

1. Pursuant to Government Code section 11517, subdivision (c)(2)(D),[1] and California Code of Regulations, title 1, section 1050, subdivision (b), the agency shall lodge the

[1] The procedure pertaining to remand set forth in Government Code section 11517, subdivision (c)(2)(D), applies in situations where an agency has not yet issued a final decision and in instances where the agency remands a decision for reconsideration by the Administrative Law Judge pursuant to Government Code section 11521, subdivision (b). An agency's remand following the granting of a writ of mandamus by the Superior Court as to

transcript of the full previous April 21 through 25, 2014 administrative hearing, all exhibits identified and received into evidence during that hearing, and the June 9, 2014 final decision of the Board with the Office of Administrative Hearings, 320 West Fourth Street, Suite 630, Los Angeles, by no later than August 31, 2015.

2. The agency must comply in all other respects with California Code of Regulations, title 1, section 1050, subdivision (a), by no later than August 31, 2015.

3. A Telephonic Trial Setting Conference (or a hearing, if sufficient information is provided in the Request to Set) will be scheduled in this case upon receipt of all documents required by this order.

IT IS SO ORDERED.

DATED: August 12, 2015

DocuSigned by:
Susan Formaker
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SUSAN L. FORMAKER
Presiding Administrative Law Judge
Office of Administrative Hearings

SLF::jvr

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an agency's final decision is not directly addressed in either Government Code section, but the procedure set forth in Government Code section 11517, subdivision (c)(2)(D), is most appropriate for this situation.

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
	)	
SCOTT EISENKOP, M.D.	)	Case No. 17-2012-224090
	)	
Physician's and Surgeon's Certificate No. G41053	)	
	)	
Petitioner	)	
	)	
	)	

ORDER DENYING PETITION FOR RECONSIDERATION

The Petition filed by Benjamin J. Fenton, Esq., attorney for SCOTT EISENKOP, M.D., for the reconsideration of the decision in the above-entitled matter having been read and considered by the Medical Board of California, is hereby denied.

This Decision remains effective at 5:00 p.m. on July 18, 2014.

IT IS SO ORDERED: July 14, 2014.

Barbara Yaroslavsky, Chair
Panel A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
	)	MBC No. 17-2012-224090
SCOTT EISENKOP, M.D.	)	
	)	
Physician's and Surgeon's Certificate No. G 41053	)	**ORDER GRANTING STAY**
	)	
	)	(Government Code Section 11521)
	)	
Respondent	)	

Benjamin J. Fenton, Esq., on behalf of respondent, Scott Eisenkop, M.D., filed a Petition for Reconsideration and Request for Stay of execution of the Decision in this matter with an effective date of July 9, 2014.

Execution is stayed until July 18, 2014.

This stay is granted solely for the purpose of allowing the Board time to review and consider the Petition for Reconsideration.

DATED: July 3, 2014

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
SCOTT EISENKOP, M.D.	Case No. 17-2012-224090
Physician's and Surgeon's Certificate No. G41053	OAH No. 2013060333
Respondent	

DECISION

The attached Proposed Decision is hereby amended, pursuant to Government Code section 11517(c)(2)(c) to correct technical or minor changes that do not affect the factual or legal basis of the proposed decision. The proposed decision is amended as follows:

1. Page 7, paragraph 24 – the date of May 21, 2013 in the first sentence will be corrected to "May 21, 2012."

The attached Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on July 9, 2014.

IT IS SO ORDERED: June 9, 2014.

MEDICAL BOARD OF CALIFORNIA

BARBARA YAROSLAVSKY, Chair
Panel A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
SCOTT EISENKOP, M.D.	Case No. 17-2012-224090
Physician's and Surgeon's Certificate Number G 41053	OAH No. 2013060333
Respondent.	

PROPOSED DECISION

This matter came on regularly for hearing on April 21-25, 2014, in Los Angeles, California, before H. Stuart Waxman, Administrative Law Judge, Office of Administrative Hearings, State of California.

John E. Rittmayer, Deputy Attorney General, represented Complainant, Kimberly Kirchmeyer (Complainant), Executive Director of the Medical Board of California (Board).

Respondent was present and was represented by Benjamin J. Fenton, Attorney at Law.

Oral and documentary evidence was received. The record was closed on April 25, 2014, and the matter was submitted for decision.

Complainant brought this action to limit Respondent's practice on grounds that his ability to practice safely is impaired because he suffers a physical illness affecting competence pursuant to Business and Professions Code section 822. For the reasons set forth below, Respondent's practice will be so limited.

FACTUAL FINDINGS

1. Complainant filed the Accusation in her official capacity.

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2. On a date not disclosed by the evidence,[1] the Board issued Physician's and Surgeon's Certificate Number G 41053 to Respondent. The certificate was in full force and effect at all relevant times. It will expire on March 31, 2015, unless renewed.

Respondent's Background

3. Respondent is a gynecologic oncologist certified by the American Board of Obstetrics and Gynecology, Division of Gynecologic Oncology. After graduating summa cum laude from the University of California, Los Angeles (UCLA), he earned his doctorate at the Chicago Medical School and served his internship and residency at the Los Angeles County/University of Southern California (LAC/USC) Medical Center and a fellowship with the Division of Gynecologic Oncology, Department of Obstetrics and Gynecology at the UCLA Medical Center. Respondent has served on the medical faculties at UCLA and Stanford University. He is extensively published.

4. Respondent enjoys a reputation as an extraordinary surgeon. He is one of the few gynecologic oncologists who practices in the San Fernando Valley. His practice extends west to Thousand Oaks. He is called in regularly by gynecologists to perform surgeries ranging from relatively simple procedures to the most complex. His surgeries tend to be more urgent than emergent. Respondent presently has privileges at five hospitals but performs most of his surgeries at only two.

5. Respondent is dedicated to his profession. He makes himself available to referring physicians at all times. He is willing to, and often does, work long hours including well into the night, and he is willing to trade sleep time in order to treat a patient in need.

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[1] Respondent's certificate was not offered into evidence. Factual Finding 2 is made on the basis of a stipulation between the parties (Exhibit 2). However, the issuance date is not included in the stipulation. Additionally, according to the Stipulation, Respondent's certificate number is A 86869. That number is incorrect. The correct certificate number, as reflected in the Accusation, is G 41053.

6. In 1996, Respondent underwent chemotherapy and radiation for lymphoepithelioma of the nasopharynx. Although the treatment was successful, it left him with xerostomia (dry mouth), tightened jaw muscles, and bilateral hearing loss. He is unable to fully open his mouth, and he is unable to drink through a straw. The area surrounding his mouth is numb. He has difficulty speaking clearly, and extended or extensive speaking creates more dryness in the mouth and increased slurring of his speech. Due to these conditions, Respondent insists on quiet in the operating room, and he prefers to work with the same people consistently because they are familiar with his limitations and are able maintain quiet and anticipate his needs, thus enabling him to hear better and speak less frequently. He also prefers to work with individuals who do not have a "language barrier" (Respondent's term) because he believes such individuals' accents make it more difficult for him to understand them and for them to understand him, thus requiring him to use his voice more than would otherwise be necessary. Those who do not regularly work with Respondent sometime find his personality and his fierce commitment to surgical excellence caustic and demanding.

7. Respondent can relieve his xerostomia to a certain extent by drinking water, which he does regularly, and by remaining silent, thereby allowing the moisture in the air inside his mouth to moisten the surrounding mucous membranes. Although he denies ever drinking water during surgery, two of the regular registered nurse first assistants with whom he has regularly worked for years have known him to do so. Some of the staff members with whom he regularly works are familiar with a set of hand signals Respondent has devised, and Respondent is able to save his voice by using those signals. However, he is unable to do so when working with someone unfamiliar with the signals.

8. In 2008, Respondent was participating in grand rounds when he suffered a seizure that precluded his ability to speak for approximately three minutes. He experienced two or three similar episodes in the ensuing months. Since that time, he has been under the care of neurologist, Arthur Kowell, M.D., for simple partial seizure disorder. Dr. Kowell presently has Respondent on therapeutic doses of Topamax and Keppra. With those medications, Respondent's seizure activity is well-controlled. However, the likelihood of a recurrence of seizure activity is increased by Respondent's maintaining extended work hours and not getting enough sleep.

9. Respondent's seizure disorder involves only speech arrest, a condition in which he is unable to form words. The condition lasts from a few seconds to a few minutes.

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The Surgery of May 21, 2012

10. On May 21, 2012, Respondent was scheduled to assist on an urgent surgery involving laparoscopic lysis of adhesions and removal of one ovary. The surgery was to take place at St. Joseph's Medical Center in Burbank, one of approximately eight hospital at which Respondent had privileges. Although the patient's regular gynecologist, David Ahdoot, M.D., was scheduled as the lead surgeon, Respondent served in that capacity due to the complexity of the procedure. Both Dr. Ahdoot and Respondent had seen the patient before and were familiar with her history and present condition.

11. That day had been a busy one for Respondent. He had performed an extensive surgery in the morning and he had been busy with office visits thereafter.

12. The surgery was scheduled to commence at approximately 5:30 p.m., but was delayed until approximately 7:00. Because of the late start time, the surgical staff assigned to the case was not the staff with whom Respondent regularly worked. However, circulating nurse, Karen Rhodes (Rhodes), and surgical technician (scrub tech), Jorge Ochoa (Ochoa), had worked with Respondent many times over the prior few years and were familiar with his preferences. English is a second language for Ochoa, and he speaks with an accent. For that reason, Respondent has found it difficult to work with him, and he had previously requested the hospital not to assign Ochoa to any of his cases.

13. Lysing the adhesions and repairing small nicks in the bowel was a slow, meticulous process lasting several hours. Respondent and Dr. Ahdoot then discovered that, during an earlier tummy tuck procedure, a surgeon had sutured part of the bowel to the abdominal wall with permanent sutures. This would require conversion of the procedure from a laparoscopy to an open laparotomy. The staff began to assemble the appropriate instrumentation for the new procedure. At the same time, some new operating room personnel arrived for shift change and received report from those going off duty. The noise level in the operating room up to that time had been quiet with minimal conversation. However, at that point, the noise volume in the operating room necessarily increased.

14. At approximately 10:24 p.m., while those changes were occurring and after the abdomen had been opened, Respondent stopped operating and became still and silent. After a few moments, he attempted to utter a few words no one in the room could understand. The anesthesiologist, Rhodes, Ochoa, and Dr. Ahdoot, each attempted to clarify what Respondent had said, but Respondent did not respond except to utter a few more incomprehensible and apparently unrelated words Rhodes described as a "mumble of consonants." They asked if he meant specific things, but again, they received only incoherent mumbles in response. Ochoa found Respondent confused, incoherent, and disoriented. He had never seen Respondent act in that manner before. Dr. Ahdoot suggested Respondent step back from the table and have a seat. Respondent was offered water or juice. However, he remained at the operating table and began to operate again. Dr. Ahdoot left the operating room for some water. He asked Rhodes to assist him in telephoning Respondent's partner, Dr. Lin.

15. The episode lasted 10-15 minutes. Upon Dr. Ahdoot's return to the operating room, Respondent continued to operate having never left the table. At one point, Respondent asked Ochoa, "What are we doing here" and "Why don't we just close" or words to that effect. Dr. Lin arrived shortly before closing began. The remainder of the surgery was uneventful, and Dr. Lin was not an active participant.

16. At one point late in the surgery, Respondent asked Rhodes for his history and physical (H&P). She gave him the H&P Dr. Ahdoot had prepared. Respondent rejected it and asked for the one he had prepared. Rhodes was unable to locate an H&P prepared by Respondent. However, it was Respondent's custom and practice to prepare an H&P for every surgery he performed and to look at it late in the surgery to ensure he had accomplished all he had planned. Therefore, the issue of the H&P is not viewed as part of the episode described in Factual Findings 14 and 15, above.

17. Also before the end of the surgery, Respondent asked the anesthesiologist if he had inserted an NG tube. Respondent had already ordered the anesthesiologist to place an NG tube at the beginning of the surgery. However, it was Respondent's custom and practice to ask again at the end of surgery, especially when bowel resection was involved, as it was in this case. Accordingly, Respondent's question to the anesthesiologist is not viewed as part of the episode described in Factual Findings 14 and 15, above.

18. However, following the surgery, Respondent asked Rhodes if the circulating nurse was still present. Except for the removal of her surgical mask, Rhodes was dressed as she had been during the lengthy surgery, and Respondent appeared not to recognize her. At the hearing, Respondent claimed there had been another circulating nurse present during the surgery. That assertion lacks merit in that it was specifically denied by Rhodes, who was likely to know which staff members were present. In addition, Respondent recalls speaking with Rhodes at the end of the surgery. It is unlikely Rhodes would still be there following the surgery if she had been relieved intra-operatively.

19. Respondent's version of the events of May 21, 2012 is much different. He testified that the problems in the operating room began at the beginning when he arrived to find that many of the instruments he needed for the laparoscopy where either missing or not plugged in, and that, when he stated he needed an omni, the circulating nurse (Rhodes) was not familiar with that device and had to go look for one. That testimony was not convincing in that (1) Dr. Ahdoot had arrived before Respondent and had not noticed any inadequacy in the instrumentation, and (2) Rhodes is an experienced circulating nurse with a Bachelor of Science in Nursing (BSN). It is extremely unlikely that she would be unfamiliar with an instrument as common as an omni.

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20. Respondent testified that the atmosphere in the operating room throughout the procedure was tense, hostile, and extremely noisy. The temperature in the room was hot, and he repeatedly had to ask for quiet throughout the procedure. Respondent's description stands in sharp contrast to the testimony of both Rhodes and Ochoa, who testified that they were aware of Respondent's preference for quiet, and that the entire staff maintained a quiet atmosphere during the procedure. It is also contrary to Dr. Ahdoot's testimony. Dr. Ahdoot testified that the noise level increased only during the shift change and instrument change, both of which occurred around the time the procedure was converted from a laparoscopy to an open laparotomy.

21. Respondent testified that, around the time he started to open the abdomen, his mouth was very dry. He rested his voice for three to four minutes. During that time, the staff repeatedly asked him if everything was alright, and he answered "Yes. I'm resting my voice." However, his speech was slurred and it sounded like mumbling. Respondent continued to operate while the staff continued to question him. He was never confused or disoriented. There was a great deal of telephone use by the staff and the anesthesiologist. He told them to stop using the telephone. At one point, the anesthesiologist actually left the patient to use his cell phone. Respondent claimed he stopped operating twice during the procedure, once when staff was changing shift, and once when they were assembling the needed instrumentation for the laparotomy. He was "frustrated" (Respondent's term) and wanted to finish the surgery. Respondent also testified that the circulating nurse kept pushing a wheeled trash cart around the operating room, and he instructed her to stop doing so. Further, his questions to Ochoa as to what they were doing there and why they shouldn't close were intended to lighten the mood and as mild sarcasm to motivate Ochoa to better perform his duties.

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22. Respondent's testimony in that regard was not convincing for the following reasons: (1) Respondent was the only one in the operating room that night who testified that the episode lasted only three to four minutes. That testimony was contradicted by both the circulating nurse and the scrub tech who also credibly contradicted Respondent's testimony about the tense and hostile atmosphere in the operating room. Dr. Ahdoot opined that the atmosphere was tense only around the time the procedure changed from a laparoscopy to a laparotomy. (2) Respondent could have easily answered the staff's questions as to whether he was alright with a nod of his head. He did not do so. (3) The only telephone referenced throughout the administrative hearing was outside of the operating room, and the testimony from all concerned, except Respondent, is that it was used only once. That call went to Dr. Lin. No evidence was offered to support the continued use of a telephone in the operating room that was causing unwanted noise, and no evidence was offered to support the need for any telephone use except for the call to Dr. Lin. (4) Respondent's description of his volitional decision to stop operating during the shift change was described by Ochoa as Respondent being somewhat frozen in place (Rhodes testified that he did not look "frozen") and by Dr. Ahdoot as Respondent being very still. (5) Before giving his testimony at the administrative hearing, Respondent never mentioned Rhodes pushing a trash cart around the operating room or the anesthesiologist using his cell phone during surgery and leaving his patient in order to do so. Following the incident, Respondent wrote a letter to the Medical Executive Committee (MEC) of St. Joseph's Medical Center and was subsequently interviewed by the committee, but he did not mention any of those events in either the letter or the interview. Respondent's embellishment of his story only at its most recent telling reflects poorly on his credibility. The descriptions of the event of May 21, 2012 by Rhodes and Ochoa are consistent and are more credible than that of Respondent for the reasons set forth above.

23. Shortly after the May 21, 2012 surgery, Respondent created a form questionnaire which he asks a staff member to fill out after every surgical procedure he performs. The form contains boxes to be used in responding to questions relating to Respondent's ability to hear and communicate during the surgery, and whether he acted in any unusual way during the procedure. He asks only individuals who were present throughout the entire procedure to fill out the form. That individual then signs and dates the form. Since the form's inception, no one has provided any negative answers.

The Interview of May 31, 2012

24. The MEC at St. Joseph's Medical Center suspended Respondent's privileges immediately upon learning of the May 21, 2013 event, pending its receipt of medical clearance by Respondent's physicians. Respondent immediately scheduled appointments with his neurologist and psychiatrist for consultation and testing. He also continued his medical practice seeing patients in his office and performing surgeries in hospitals where his privileges were not suspended. On May 23, 2012, believing there had been either a misunderstanding or a conspiracy in the operating room (Respondent's testimony), Respondent wrote a letter to the MEC at St. Joseph's Medical Center explaining his version of the event of May 21, 2012 (Exhibit F).

25. On May 31, 2012, Respondent attended an interview with the MEC at St. Joseph's Medical Center. He was accompanied by his attorney, Tom Curtis.[2] At the administrative hearing, Respondent testified he believed the purpose of the interview was solely for him to establish that his physicians had medically cleared him to practice. Were this actually the case, it is difficult to understand why he felt the need to be represented by counsel, especially since the MEC had already received copies of Respondent's magnetic resonance imaging studies and written clearances from his physicians.

26. Respondent had slept very little the night before the interview.[3] At the interview, Respondent began with a lengthy narrative of the May 21, 2012 event. He drank water as he spoke. Approximately 30 minutes into the interview, by Respondent's estimate, Respondent suddenly became non-responsive to the committee members' questions concerning the incident. For example:

UNKNOWN: . . . Did you ask for any water during the case with a straw at all?

DR. EISENKOP: Right.

UNKNOWN: Did you?

DR. EISENKOP: Right.

MR. CURTIS: No, he wants to know if you asked for it during the case. Did you ask for water during the case?

DR. EISENKOP: Right.

MR. CURTIS: Did you?

DR. EISENKOP: Yes. I mean, anybody they can do, anybody can. Anybody can do that.

UNKNOWN: Did you drink?

DR. EISENKOP: Anybody can have a drink.

MR. CURTIS: Did you drink water during the case?

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[2] As indicated above, Mr. Curtis did not represent Respondent at the administrative hearing.

[3] He alternately stated during the interview that he had gone to bed at 2:30, that he had gone to bed at 3:00, that he had had "an emergency," and that people had been calling him during the night. (Exhibit 3.)

DR. EISENKOP: Yes. Anybody can do that.

UNKNOWN: Did you want to know why you were asked to step away?

DR. EISENKOP: I missed it perhaps.

UNKNOWN: Did you ask, did want (*sic*) to know why you were asked to step away from the patient?

DR. EISENKOP: I just figured, I guess.

UNKNOWN: Did you want to know why you were asked to step away from the patient?

DR. EISENKOP: I'm tired. What?

UNKNOWN: Did you want to know why you were asked to step away from the patient?

DR. EISENKOP: I'm so tired. I missed it. Huh?

MR. CURTIS: Let me say it to him.

UNKNOWN: Yeah. Why don't you tell him?

MR. CURTIS: Okay. During the case . . .

DR. EISENKOP: Yes.

MR. CURTIS: . . . the nurses asked you to step away.

DR. EISENKOP: Yes.

MR. CURTIS: Did you want to know why?

DR. EISENKOP: Yes.

MR. CURTIS: Did you ask?

DR. EISENKOP: Yes, I did. I'm very tired. I'm tired.

MR. CURTIS: Right now?

DR. EISENKOP: Yes.

UNKNOWN: Okay. Do you feel good? Are you okay?

DR. EISENKOP: Yes, just tired, very tired.

UNKNOWN: Are you having trouble hearing?

DR. EISENKOP: Yes, I'm just tired right now. Hold on.

UNKNOWN: Okay.

DR. EISENKOP: Okay. Now what did they say?

MR. CURTIS: When the nurses asked you to step away . . .

DR. EISENKOP: Yes.

MR. CURTIS: . . . did you ask why?

DR. EISENKOP: Yes. They could do it.

UNKNOWN: You . . .

DR. EISENKOP: What they said, I was very upset. Right.

MR. CURTIS: Okay. So did . . .

UNKNOWN: Why don't we take a break, yeah?

MR. CURTIS: Okay.

UNKNOWN: Go ahead.

UNKNOWN: He might want to take a walk outside.

MR. CURTIS: Sure. Scott, let's step outside for a while and take a break.

DR. EISENKOP: Yes. If it's okay, you bet.

MR. CURTIS: Okay. Let's take a little walk. Thank you.

DR. EISENKOP: No, I want to get it right.

MR. CURTIS: Now, we're gonna take a break and rest and then come back.

DR. EISENKOP: I feel, I feel so bad.

MR. CURTIS: It's okay, Scott.

DR. EISENKOP: Let me tell you something.

MR. CURTIS: Thanks very much, Greg.

DR. MESROBIAN: Oh, no, no.

DR. EISENKOP: (inaudible) take advantage. The problem is, I went to bed at 2:30 a.m. I didn't tell you that. And I went to bed at 3:00 a.m. I had an emergency. But can we continue, please?

UNKNOWN: Oh, sure.

DR. EISENKOP: Now who was next?

UNKNOWN: Did you want to know why Dr. Lin was called?

DR. EISENKOP: Yeah, but can you start over?

UNKNOWN: Yes. Did you want to know why Dr. Lin was called?

DR. EISENKOP: No. Could you start over?

UNKNOWN: He did.

UNKNOWN: Did you ask why Dr. Lin was called?

DR. EISENKOP: No, tell me why?

UNKONWN: I'm asking you. Did you want to know?

DR. EISENKOP: Start over again, please.

UNKNOWN: Did you want to know why Dr. Lin was called that night?

DR. EISENKOP: No. Can you tell me again? Start over.
(Exhibit 3, pages 10-14.)

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27. At the administrative hearing, Respondent admitted that some of his answers to the questions during the May 31, 2012 interview were not responsive. However, he explained that he had a very discordant relationship with most of the committee members, and that his attorney had advised him to keep his answers short and to avoid saying anything that could be construed as negative.[4] Because he therefore had to contemplate the answers to the questions instead of answering as he wanted to, he used his non-responsive answers as a way to "buy time" (Respondent's term) in order to search for appropriate answers to the questions. In addition, the committee member who asked him the question regarding whether he drank water during the surgery had asked him a similar question in another proceeding, and Respondent was both offended and humiliated to have to answer it again.

28. That explanation was not credible. First, even if his attorney had given Respondent the advice Respondent claims, the same attorney seemed as puzzled by the answers as the committee members were. In fact, Respondent's attorney asked Respondent the very same questions the committee members did, and attempted to assist the committee members in obtaining the answers to their questions. When that failed to elicit responsive answers, Respondent's attorney attempted to take Respondent on a break. Secondly, the questions concerning whether he drank water during the surgery, whether he wanted to know why he was asked to step away from the operating table, and whether he wanted to know why Dr. Lin was called, all could be answered with "yes" or "no" without any negative connotation or lengthy narrative. Third, Respondent's non-responsiveness was not an attempt to "buy time" to find an answer that would be short in compliance with his attorney's advice. He had already disregarded his attorney's advice by engaging in a long narrative concerning the events of May 21. Fourth, Respondent did not "buy time" to develop an appropriate answer. He failed to answer responsively at all. Finally, Respondent's claim of extreme fatigue was not convincing in that it was inconsistent with his penchant for working extremely long hours on very little rest. Respondent claims he used fatigue as a method of delay to frame appropriate answers to the questions. However, that claim is inconsistent with his resistance to taking a break and wanting to continue with the interview.

29. Following the May 31, 2012 interview, the MEC of St. Joseph's Medical Center left Respondent's suspension of privileges in place. Respondent has not worked at that hospital since May 21, 2012.

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[4] Respondent waived the attorney-client privilege in that regard.

Privileges at Providence Tarzana Medical Center

30. Providence Tarzana Medical Center also suspended Respondent's privileges after the May 21, 2012 incident at St. Joseph's Medical Center and, in connection with that suspension, Respondent was referred to Donald Sutherling, M.D. for evaluation. Dr. Sutherling performed a number of video EEG's on Respondent. On June 11, 2012, the EEG was abnormal, showing multiple bilateral anterial temporal spikes on the left which awakened him from sleep but without confusion upon awakening. Dr. Sutherling interpreted those spikes as a partial seizure disorder. Video EEG's on July 17, 2012 and August 21, 2012 resulted in a modification of his medication dosages. The July 17, 2012 EEG showed the same kinds of spikes as did the June 11, 2012 EEG, and possibly right side spikes as well. The condition was improved on August 21, 2012 following the medication adjustment. Dr. Sutherling opined that Respondent needed to restrict the number of hours he worked in order to minimize the risk of seizures.

31. On November 11, 2012, Respondent entered into an agreement with the MEC at Providence Tarzana Medical Center[5] according to which his privileges were restored subject to the following terms and conditions:

> 1, Have EEGs in accordance with Dr. Sutherling's recommendations. The EEGs can be performed by Dr. Kowell, if you wish.
>
> 2. If the EEGs are performed by Dr. Kowell or someone other than Dr. Sutherling, sign an authorization and release for that physician to send the EEG and information to Dr. Sutherling (or another physician who may be selected by the MEC) for his review.
>
> 3. Sign an authorization and release for Dr. Sutherling (or another physician who may be selected by the MEC) to communicate with the Medical Staff regarding your condition as it may affect your ability to safely practice.
>
> 4. Limit the total of your office hours and surgery hours to 50 hours per week.

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[5] Respondent also claimed a "stressful and negative" relationship with the MEC at Providence Tarzana Medical Center due to "politics and competition." (Respondent's terms.)

5. Not schedule surgical cases at Providence Tarzana Medical Center to commence after 2 pm. If you are not available to start your scheduled case until after 2 pm, the case will be cancelled and may be rescheduled. If there is an emergency case and you determine it would be unsafe to postpone the case until the next morning, you may proceed with the emergency case. However, within 24 hours of completing the surgery, you must notify the Surgery Department Chair in writing of the case, why it was an emergency, and why it would have put the patient at unavoidable risk to delay the case until the next morning.

6. Establish and comply with a call arrangement with another GYN/Oncologist so that you are not on call all of the time, but share equally coverage with the other GYN/Oncologist. You will provide the Medical Staff the name of the GYN/Oncologist with whom you are sharing call coverage. (This is not to limit you from establishing call with more than one other GYN/Oncologist, provided you do not take more than 50% of the call.)

7. Use a surgeon as your assistant in all laparotomy and laparoscopic procedures at Providence Tarzana Medical Center.

8. On a weekly basis, submit to the Medical Staff Office your office schedule, your surgery schedule (to include all surgeries in which you are present, including all facilities) and sleep log (to include total of the hours per day, not the specific times). The MECs designee will review the materials to verify that the total reported office hours and time expected for the reported surgeries should not have exceeded 50 hours per week and that you are averaging at least 7 hours of sleep a night. If the Medical Staff has questions, you will promptly provide the requested information within 72 hours of receipt of the request. You are responsible for assuring these materials and all requested information are timely delivered to the Medical Staff Office with a receipted delivery. Should the materials or information not be timely received, you must promptly provide the tracking number and tracking information to the Medical Staff.

(Exhibit 4.)

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32. Respondent signed the agreement under language stating in part: "I agree that the restrictions and monitoring described in this letter are reasonable and warranted and that I will comply with each of the requirements." (*Id.*) However, at the administrative hearing, he denied that the terms and conditions imposed by Providence Tarzana Medical Center were either reasonable or warranted, and he claimed that the restrictions placed on his surgery time were "irrelevant and arbitrary." (Respondent's terms.) Respondent explained that it serves no purpose to limit his working hours because working hours can be defined in various ways. For example, depending on how a surgery is defined, the same procedure can have lasted three hours or ten hours. Respondent believes the condition imposed by the MEC is therefore irrelevant to whether he gets sufficient rest.

The Experts

33. Complainant offered the expert testimony of retired neurologist, Kannen Paramesh, M.D. Dr. Paramesh retired from the practice of medicine in October 2013. He examined Respondent in February 2013. Dr. Paramesh's recent retirement does not impact on his competence to render expert opinions in this case.

34. Respondent offered the expert testimony of neurologists, Loren Label, M.D., Harris Fisk, M.D., and Arthur Kowell, M.D. (Respondent's treating neurologist), and psychiatrist, Brian Jacks, M.D. Each of those physicians was well qualified to offer expert opinions.

35. All of the experts agreed that Respondent suffers from a seizure disorder borne of changes in the brain as a result of his 1996 cancer treatment. There is some variance of opinion as to whether any of his seizures have been complex partial seizures as opposed to simple partial seizures, with those hired by Respondent favoring the latter, and Dr. Paramesh claiming the former in his report, but only acknowledging the possibility in his testimony. The consensus among the experts is that Respondent's seizure disorder is manifested by speech arrest. All of the experts agree that lack of sleep increases the risk of seizures and that, to minimize the risk, Respondent must maintain compliance with a strict regimen of medication prescribed at therapeutic levels, and he must get adequate rest.

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36. Dr. Paramesh opined that Respondent suffered a simple partial psychic seizure during the surgery of May 21, 2012. Psychic seizures are marked by confusion, garbled speech, an inability to find the correct words to communicate, memory loss, and an unawareness of conscious state. Dr. Kowell acknowledged that possibility but with the caveat that Respondent has a speech impediment that can be misinterpreted. Dr. Jacks also acknowledged the possibility of a simple partial seizure but found no evidence of one because Respondent showed no automatic uncontrolled movements consistent with such seizures. He also opined that simple partial seizures do not interfere with an individual's ability to function.[6]

37. Dr. Paramesh found the episode of May 31, 2012 suspicious of seizure, but he was unable to opine as to whether it was of the complex or simple type.

38. Dr. Fisk acknowledged the possibility of a seizure on May 31, 2012, but opined that it was more likely stress-related due to confusion because Respondent's answers were challenged. A review of the transcript and/or recording of the interview reveals that Respondent's answers were not being challenged. The questioners, including his own attorney, were simply attempting to understand what Respondent was saying.

39. Dr. Kowell offered several theories for what occurred on May 31, 2012 including fatigue and stress from sleep deprivation, anxiety, depersonalization, and fugue state. He also acknowledged the possibility that Respondent may have suffered a seizure. There is no evidence that Respondent has ever suffered from depersonalization disorder or fugue. The theory that he was stressed and anxious was undermined by his affect during his testimony at the administrative hearing in which he appeared relaxed and confident.

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[6] No other experts referred to such uncontrolled movements as indicative of a simple partial seizure, and the remainder of the experts found the only manifestation of Respondent's simple partial seizures to be speech arrest. Dr. Jacks' opinion that simple partial seizures do not interfere with an individual's ability to function is undermined by Respondent's inability to form words during a seizure, an essential form of communication for a surgeon. Dr. Jacks' opinion on this subject is given little weight.

40. Dr. Jacks testified that Respondent did not suffer a seizure on May 31, 2012. Rather, his non-responsive actions were a function of fatigue, stress, his obsessive/compulsiveness, his need to be in control, and an inability to communicate well with other people. Respondent's dry mouth interfered with his communication. When questioned near the end of his testimony as to why the episode occurred in the middle of the interview rather than at the beginning, Dr. Jacks opined that it was a function of Respondent being passive-aggressive toward the interviewers, and that the passive-aggressiveness stemmed from his stress response based on his personality. Dr. Jacks' testimony was not credible. He had conducted a psychiatric evaluation on Respondent which included administration of the Minnesota Multiphasic Personality Inventory-2 (MMPI-II), and a three-hour interview. His primary diagnosis was adjustment disorder with mixed emotional features and obsessive/compulsive personality features. At no time earlier in his testimony did he ever mention passive/aggressive behavior. He did not testify that he found any indication of passive/aggressiveness in Respondent during their interview, or that passive/aggressive behavior was noted on the results of the MMPI-II. He did not diagnose passive/aggressive personality disorder, traits, or even features. Similarly, his diagnosis is devoid of any mention of stress disorder or stress-related traits or features.

41. None of Respondent's experts explained how their theories of what occurred on May 31, 2012 reconciled with the fact that the episode occurred in the middle of the interview as opposed to near the beginning when stress and anxiety would normally be higher.

LEGAL CONCLUSIONS

1. Cause exists to suspend or revoke Respondent's certificate, pursuant to Business and Professions Code section 822, for having a physical illness affecting competency, as set forth in Findings 5 through 41.

2. The standard of proof applicable to this case is clear and convincing evidence to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) This means the burden rests on Complainant to establish the charging allegations by proof that is clear, explicit and unequivocal--so clear as to leave no substantial doubt, and sufficiently strong to command the unhesitating assent of every reasonable mind. (*In re Marriage of Weaver* (1990) 224 Cal.App.3d 478.) "Evidence of a charge is clear and convincing so long as there is a 'high probability' that the charge is true. [Citations.] The evidence need not establish the fact beyond a reasonable doubt." (*Broadman v. Comm'n on Judicial Performance* (1998) 18 Cal.4th 1079, 1090.)

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3. Business and Professions Code section 822 states:

> If a licensing agency determines that its licentiate's ability to practice his or her profession safely is impaired because the licentiate is mentally ill, or physically ill affecting competency, the licensing agency may take action by any one of the following methods:
>
> (a) Revoking the licentiate's certificate or license.
>
> (b) Suspending the licentiate's right to practice.
>
> (c) Placing the licentiate on probation.
>
> (d) Taking such other action in relation to the licentiate as the licensing agency in its discretion deems proper.
>
> The licensing agency shall not reinstate a revoked or suspended certificate or license until it has received competent evidence of the absence or control of the condition which caused its action and until it is satisfied that with due regard for the public health and safety the person's right to practice his or her profession may be safely reinstated.

4. The trier of fact may reject the testimony of a witness, including an expert witness, even if it is uncontradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) The trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected available material." (*Id.* at 67-68.)

5. Complainant correctly argued that she does not have to prove Respondent suffered either a complex partial seizure or a simple complex seizure on May 21 or May 31, 2012. She need only prove the elements in Business and Professions Code section 822. Respondent has a history of a seizure disorder that has manifested on a number of occasions. Seizure activity was demonstrated on the EEG temporally closest to the two dates involved with this case. Dr. Sutherling found the spikes recorded on the EEG highly correlated to a seizure disorder.

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6. Respondent experienced two unusual occurrences in May 2012. The first one occurred during surgery and manifested in his inability to speak to the operative staff for between 10 and15 minutes. This not only placed his patient at risk, a potential inability of a lead surgeon to communicate with his staff for 10 to 15 minutes places at risk every patient on whom the surgeon operates. Although Respondent has a set of hand signals for use with staff members he knows very well, the evidence showed he also works with individuals he does not know well. Accordingly, Respondent cannot, and does not, rely on hand signals in every surgical procedure. Nor does the questionnaire Respondent created for completion by surgical staff members solve the problem. Those questionnaires show what happened (or didn't) during a given surgery. However, they do not address the potential risk of Respondent suffering a seizure while operating. A negative questionnaire will do no good if a patient is harmed because Respondent suffered a seizure during surgery.

7. For the reasons set forth above, Respondent's version of the events of May 21, 2012 was not convincing. Although he claims to have been the victim of a misunderstanding or a conspiracy, neither was established by the evidence.

8. The second occurrence took place 10 days later, on May 31. Although Respondent's experts attribute that occurrence variously to stress, nervousness, fatigue, passive-aggressive behavior and the like, Respondent has no history of any such conditions. However, he does have a history of a seizure disorder. Further, Respondent failed to account for the fact that he had no difficulty speaking at great length during the first portion of the interview with the MEC of St. Joseph's Medical Center, but suddenly became confused and non-responsive well into the interview, being unable to answer a simple question as to whether he consumed water during the May 21, 2012 surgery with the word "no."

9. Had Respondent become non-responsive on May 31, 2012 due to fear of losing his hospital privileges, as was suggested during the hearing, that fearfulness should have been at least as strong, if not stronger, at the administrative hearing, where his license to practice medicine, rather than his hospital privileges, was at risk. However, during the administrative hearing, he was calm, confident, and focused, and he was able to articulate his words in such a way that it was not difficult to understand him.

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10. Business and Professions Code section 2229 states:

(a) Protection of the public shall be the highest priority for the Division of Medical Quality, the California Board of Podiatric Medicine, and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority.

(b) In exercising his or her disciplinary authority an administrative law judge of the Medical Quality Hearing Panel, the division, or the California Board of Podiatric Medicine, shall, wherever possible, take action that is calculated to aid in the rehabilitation of the licensee, or where, due to a lack of continuing education or other reasons, restriction on scope of practice is indicated, **to order restrictions as are indicated by the evidence.**

(c) It is the intent of the Legislature that the division, the California Board of Podiatric Medicine, and the enforcement program shall seek out those licensees who have demonstrated deficiencies in competency and then take those actions as are indicated, with priority given to those measures, including further education, restrictions from practice, or other means, that will remove those deficiencies. **Where rehabilitation and protection are inconsistent, protection shall be paramount.** (Emphasis added.)

11. This does not mean that Respondent's certificate must be revoked because he might suffer a simple partial seizure while at work. In fact, Complainant did not request license revocation. She contends, and the Administrative Law Judge concurs, that a period of properly-conditioned probation should adequately protect the public's health, safety, welfare, and interest. Respondent argues that this is unnecessary because he is under the care of a neurologist who treats his seizure disorder with appropriate medication and periodically checks his serum levels. Respondent further claims he does, and will, get adequate rest. For the reasons set forth below, those claims are inadequate to enable Respondent to forgo Board supervision.

12. The experts agreed that the risk of seizure can be minimized by maintaining an appropriate medication regimen at therapeutic dosages as determined by periodic blood tests, by Respondent remaining in compliance with his medication regimen, and by Respondent getting adequate rest. However, Respondent prides himself on his work ethic. He works long hours taking on as many referrals as he can, even when it means working long into the night. Although he testified at the administrative hearing that he averages approximately seven hours of sleep per night, he took on a somewhat defiant attitude toward the "rest requirement" in the agreement with the MEC at Providence Tarzana Medical Center that restored his privileges at that hospital, claiming that it was "irrelevant and arbitrary," and he demonstrated ways to "get around" its constraints.

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13. Accordingly, the Board cannot count on Respondent to ensure his own adequate rest and compliance with his neurologist's orders. The evidence established that Respondent is a strong-willed individual who insists on being in control of what is occurring in his life, be it the personnel comprising the staff with whom he works in the operating room, hospital management personnel, or his own personal well-being such as determining the ratio of patient care to sleep he is willing to maintain. The only way to ensure Respondent's continued work without increasing the risk of seizures through medication non-compliance and/or inadequate rest is through Board supervision. Respondent's belief that he will remain compliant and rested is laudable but unenforceable. Respondent believes his duty is to his patients. The Board's duty is to the public. The two are not mutually exclusive, but they are different.

14. Respondent also argued that, despite his seizure disorder, the California Department of Motor Vehicles (DMV) permits him, and other individuals with simple partial seizure disorders, to drive. He reasons that, since having a seizure while driving a motor vehicle has the potential of causing great personal injury and property damage, it follows that, if he can be permitted to drive without restriction, he should be able to perform surgery without restriction. Although, on its face, this is an interesting argument, it is not persuasive. First, Respondent did not offer into evidence the standards DMV uses in determining whether an individual with a seizure disorder is permitted to maintain his/her driving privilege. The standard used by that agency may not match that used by the Board. Secondly, if DMV builds in a margin of error such that it is willing to risk bodily injury and property damage, the Board is not required to follow suit. Finally, the manifestation of Respondent's disorder, specifically speech arrest, does not disqualify him from driving. He does not need his voice or his ability to form verbal words while he drives, but his voice and his ability to form verbal words are essential during surgery.

15. Respondent argued that his surgical skills are so extraordinary that the loss of his availability to practice without restriction would have a calamitous effect on the medical community he serves, and he offered the testimony of various health care professionals to corroborate that claim. No one on either side challenged or disputed the quality of Respondent's surgical skills. However, those skills must be used judiciously by ensuring that Respondent minimizes his risk of intra-operative seizure by compliance with his medication regimen, periodic blood tests to ensure therapeutic dosages, and adequate rest. To the extent that only a limited number of gynecological oncologists practice in Respondent's geographic area, Respondent acknowledged that more physicians are entering the field regularly. Further, the medical community is not being entirely deprived of Respondent's skills. Respondent is only being limited in a manner that will maximize patient safety. His patients will still have access to his skills, albeit not at all hours. Because most of his cases are non-emergent, and because emergent cases are excluded from the Order in this case, patient inconvenience should be minimized. Because he will be required to properly maintain his medication regimen and receive adequate rest, patient safety will be maximized.

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16. Complainant argued that one of the terms of probation should be the inclusion of a practice monitor. It is unclear what a practice monitor could accomplish in this case. This is not a matter of proper patient care, proper billing, or adequate and accurate record keeping. It is solely a matter of Respondent minimizing his risk of seizure. The onus for that falls entirely on Respondent. However, to ensure patient safety, an assistant surgeon, capable of assuming Respondent's duties, must be present for the duration of each surgical procedure Respondent performs during the probationary period.

17. During the administrative hearing, Complainant also took the position that Respondent should be required to undergo periodic EEG's. The evidence adduced during the hearing showed that such tests were unnecessary on a regular basis, and Complainant withdrew from that position.

18. Respondent has faced and overcome numerous difficulties since contracting cancer in 1996. In so doing, he has had to make multiple adjustments to the way he lives and the way he practices medicine. The imposition of probation to ensure public safety is one more such adjustment that Respondent must make to continue the high quality of patient care for which he is known. In order to ensure he is practicing as safely as possible under the circumstances, he must be subject not only to the Board's standard terms and conditions of probation, but also to custom terms and conditions including continued medical evaluation and treatment, ongoing blood testing, limitation of working hours, and the use of an assistant surgeon in all surgical procedures. Because his seizure disorder is likely to continue for the rest of his life, a lengthy term of probation is required.

19. For the most part, the Board's model terms (Medical Board of California Manual of Model Disciplinary Orders and Disciplinary Guidelines, 11th ed. 2011) are followed in the Order below. Some of the terms and conditions of probation are "custom" terms written pursuant to Business and Professions Code sections 822, subdivision (d) and 2229, subdivision (b). For those terms and conditions, the Board's model terms are used for guidance and as models. For example, Condition No. 1 in the Order is based in part on Model Term No. 22, and Condition No. 2 is based in part on Model Term No. 11.

ORDER

Certificate No. G 41053 issued to Respondent, Scott Eisenkop, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for ten years upon the following terms and conditions.

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1. Medical Evaluation and Treatment

Within 30 calendar days of the effective date of this Decision, and no fewer than every six months thereafter as may be required by the Board or its designee, Respondent shall undergo a medical evaluation by a Board-appointed physician who shall consider any information provided by the Board or designee and any other information the evaluating physician deems relevant and shall furnish a medical report to the Board or its designee. Respondent shall provide the evaluating physician any information and documentation that the evaluating physician may deem pertinent.

Following the evaluation, Respondent shall comply with all restrictions or conditions recommended by the evaluating physician within 15 calendar days after being notified by the Board or its designee. If Respondent is required by the Board or its designee to undergo medical treatment, Respondent shall, within 30 calendar days of the requirement notice, submit to the Board or its designee for prior approval the name and qualifications of a California licensed treating physician of Respondent's choice. Upon approval of the treating physician, Respondent shall, within 15 calendar days, undertake medical treatment and shall continue such treatment until further notice from the Board or its designee.

The treating physician shall consider any information provided by the Board or its designee or any other information the treating physician may deem pertinent prior to commencement of treatment. Respondent shall have the treating physician submit quarterly reports to the Board or its designee indicating whether or not Respondent is capable of practicing medicine safely. Respondent shall provide the Board or its designee with any and all medical records pertaining to treatment, the Board or its designee deems necessary.

If, prior to the completion of probation, Respondent is found to be physically incapable of resuming the practice of medicine without restrictions, the Board shall retain continuing jurisdiction over Respondent's license and the period of probation shall be extended until the Board determines that Respondent is physically capable of resuming the practice of medicine without restrictions. Respondent shall pay the cost of the medical evaluation(s) and treatment.

Respondent shall not engage in the practice of medicine until notified in writing by the Board or its designee of its determination that Respondent is medically fit to practice safely.

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2. Blood Testing

Within 30 calendar days of the effective date of this Decision, and no less than every six months thereafter, Respondent shall undergo testing of his blood to ensure medication he is taking for seizure disorder is maintained at therapeutic levels. Prior to practicing medicine, Respondent shall contract with a laboratory or service approved in advance by the Board or its designee that will conduct the blood testing. The contract shall require results of the tests to be transmitted by the laboratory or service directly to the Board or its designee within four hours of the results becoming available. Respondent shall maintain this laboratory or service contract during the period of probation. Respondent shall be responsible for all costs connected with this probationary term.

A certified copy of any laboratory test result may be received in evidence in any proceedings between the Board and Respondent.

The failure of Respondent to comply with this condition shall be considered a violation of probation.

3. Limitation on Work-Related Hours

Respondent shall limit his work-related hours to periods of no more than 10 consecutive hours. "Work-related hours" are defined as those hours in which Respondent is performing any of the duties of a physician and surgeon including but not limited to performing surgery, assisting in surgical procedures, time spent between a surgery's scheduled start time and its actual start time, giving other medical treatment, consultation with patients, other physicians, and other medical personnel, patient examination, travel to and from office and hospitals for patient care, chart and/or report writing, teaching, and medical research. The cessation of any consecutive work-related hours, even if fewer than 10 consecutive hours, shall be followed by no fewer than nine consecutive hours spent in activities other than performing the duties of a physician and surgeon. This condition is intended to ensure Respondent receives adequate rest so as to minimize the risk of seizures during work-related hours.

Respondent shall not schedule any surgeries or other work-related activities in a manner that may risk his having to perform work-related activities following the 10 consecutive hour allotment.

This condition of probation shall not apply to emergent cases. However, within 24 hours of completion of any such emergent surgery, Respondent shall notify the Board or its designee that he performed an emergent procedure following the expiration of the 10 consecutive hour work-related allotment, the nature of the case, why Respondent considered the case emergent, and why he believed the procedure could not have been performed on an urgent basis within a 10 consecutive hour work-related allotment without placing the patient at undue risk.

Any emergent procedure that requires Respondent to engage in work-related activities beyond the 10 consecutive hour work-related allotment shall be followed by no fewer than nine consecutive hours of non-work-related time.

Respondent shall maintain a monthly log including, at minimum, the date, the beginning and ending times of consecutive hours spent in work-related activities, the beginning and ending times of consecutive hours spent in non-work-related activities, and the beginning and ending times in excess of the 10 consecutive hour allotment while he was engaged in an emergent case(s). Respondent shall provide to the Board or its designee a copy of each monthly log within 10 days of the end of the month covered by that log.

The failure of Respondent to comply with all aspects of this condition shall be considered a violation of probation.

4. Utilization of Assistant Surgeon During Surgeries

On each and every case in which Respondent serves as the primary surgeon, regardless of the case's nature and/or requirements, Respondent shall utilize the services of an assistant surgeon who is qualified and capable of assuming the duties and responsibilities of the primary surgeon. Another gynecological oncologist, qualified gynecologist, or general surgeon shall qualify for this purpose. The assistant surgeon shall be present throughout the course of the surgical procedure. Respondent shall not utilize the services of a registered nurse first assistant in place of an assistant surgeon on any such case.

5. Notification

Within seven days of the effective date of this Decision, Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

6. Supervision of Physician Assistants

During probation, Respondent is prohibited from supervising physician assistants.

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7. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

8. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

9. General Probation Requirements

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

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Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

10. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

11. Non-Practice While on Probation

Respondent shall notify the Board or its designee, in writing, within 15 calendar days, of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

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12. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

13. License Surrender

Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall, within 15 calendar days, deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

14. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

15. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

Dated: May 7, 2014

H. Stuart Waxman

H. STUART WAXMAN
Administrative Law Judge
Office of Administrative Hearings

Benjamin J. Fenton, State Bar No. 243214
bfenton@fentonlawgroup.com
FENTON LAW GROUP, LLP
1990 South Bundy Drive, Suite 777
Los Angeles, California 90025
Tel. (310) 444-5244 / Fax (310) 444-5280

Attorneys for Petitioner
SCOTT EISENKOP, M.D.

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES

SCOTT EISENKOP, M.D., Petitioner, vs. MEDICAL BOARD OF CALIFORNIA Respondent.	Case No. BS149900 [PROPOSED] JUDGMENT DENYING IN PART AND GRANTING IN PART ADMINISTRATIVE WRIT OF MANDAMUS Place: Dept. 85 Hon. James C. Chalfant, Judge.

This matter came regularly before this Court on April 14, 2015, for hearing in Department 85 of the Superior Court, the Honorable James C. Chalfant presiding. Benjamin J. Fenton appeared as attorney for Petitioner; Deputy Attorney General Colleen M. McGurrin appeared on behalf of Respondent Medical Board of California. Having read and considered the papers and pleadings filed by the parties and having considered the oral argument of counsel with respect thereto, the Court made various determinations, as set forth in a Tentative Ruling adopted as the Final Ruling of Court dated April 14, 2015, attached hereto as Exhibit 1 and incorporated by reference herein, the Court orders as follows:

IT IS ORDERED that:

1. The Petition for Writ of Administrative Mandate is denied in part and granted in part. Respondent is to remain on Probation pursuant to the terms and conditions in the Decision dated June 9, 2014, in the administrative proceeding entitled "In the Matter of the Accusation Against: Scott Eisenkop, M.D.", Case No. 17-2012-224090, OAH No. 2013060333 ("Respondent's Decision"), except as provided below.

2. A Writ of Mandamus shall issue from the Court, ordering Respondent to either delete or modify with Petitioner's consent condition number 4 entitled "Utilization of Assistant Surgeon During Surgeries" set forth in Respondent's Decision or to remand the matter to hold a further evidentiary hearing concerning that condition.

3. The Writ shall further command Respondent to delete or modify with Petitioner's consent condition number 3 entitled "Limitation on Work-Related Hours" set forth in Respondent's Decision or remand the matter to hold a further evidentiary hearing concerning the definition of work-related hours only.

4. The parties are to return after remand on October 13, 2015 at 9:30 a.m.

Date: 5/14/15

JUDGE OF THE SUPERIOR COURT
JAMES C. CHALFANT

Approved as to form:

Dated: 5/14/15

By: Colleen McGurrin
Colleen M. McGurrin
Deputy Attorney General
Attorneys for Respondent

FILED
Superior Court of California
County of Los Angeles
APR 14 2015
Sherri R. Carter, Executive Officer/Clerk
By Annie Espinoza Deputy
Annie Espinoza

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Eisenkop, M.D. v. Medical Board of California
BS 149900

Tentative decision on petition for writ of mandate: denied in part, granted in part

Petitioner Scott Eisenkop, M.D. ("Eisenkop") applies for a writ of administrative mandamus overturning the decision by the Medical Board of California ("Board") to place his license to practice medicine on probation for ten years.

The court has read and considered the moving papers, opposition, and reply, and renders the following tentative decision.

A. Statement of the Case

Petitioner commenced this proceeding on July 18, 2014, seeking to overturn the Board's June 9, 2014 decision to revoke his license, stay the revocation and ordering ten-year probation with conditions.

B. Standard of Review

CCP section 1094.5 is the administrative mandamus provision which structures the procedure for judicial review of adjudicatory decisions rendered by administrative agencies. Topanga Ass'n for a Scenic Community v. County of Los Angeles, ("Topanga") (1974) 11 Cal.3d 506, 514-15. The pertinent issues under section 1094.5 are (1) whether the respondent has proceed without jurisdiction, (2) whether there was a fair trial, and (3) whether there was a prejudicial abuse of discretion. CCP §1094.5(b). An abuse of discretion is established if the respondent has not proceeded in the manner required by law, the decision is not supported by the findings, or the findings are not supported by the evidence. CCP §1094.5(c).

Section 1094.5 does not in its face specify which cases are subject to independent review. Fukuda v. City of Angels (1999) 20 Cal.4th 805, 811. Instead, that issue was left to the courts. In cases reviewing decisions which affect a vested, fundamental right the trial court exercises independent judgment on the evidence. Bixby v. Pierno, (1971) 4 Cal.3d 130, 143. *See* CCP §194.5(c). The right to practice a trade or profession is deemed to be a fundamental right requiring application of the independent judgment test. Goldy v. Fox, (1979) 98 Cal.App.3d 167, 173.

Under the independent judgment test, "the trial court not only examines the administrative record for errors of law but also exercises its independent judgment upon the evidence disclosed in a limited trial de novo." Id. at 143. The court must draw its own reasonable inferences from the evidence and make its own credibility determinations. Morrison v. Housing Authority of the City of Los Angeles Board of Commissioners, (2003) 107 Cal.App.4th 860, 868. In short, the court substitutes its judgment for the agency's regarding the basic facts of what happened, when, why, and the credibility of witnesses. Guymon v. Board of Accountancy, (1976) 55 Cal.App.3d 1010, 1013-16.

However, "[i]n exercising its independent judgment, a trial court must afford a strong presumption of correctness concerning the administrative findings, and the party challenging the administrative decision bears the burden of convincing the court that the administrative findings are contrary to the weight of the evidence." Fukuda v. City of Angels 20 Cal.4th at 817. Unless

it can be demonstrated by petitioner that the agency's actions are not grounded upon any reasonable basis in law or any substantial basis in fact, the courts should not interfere with the agency's discretion or substitute their wisdom for that of the agency. Bixby v. Pierno, (1971) 4 Cal.3d 130, 150-151; Bank of America v. State Water Resources Control Board, (1974) 42 Cal. App.3d 198, 208.

The agency's decision must be based on the evidence presented at the hearing. Board of Medical Quality Assurance v. Superior Court, (1977) 73 Cal.App.3d 860, 862. The hearing officer is only required to issue findings that give enough explanation so that parties may determine whether, and upon what basis, to review the decision. Topanga, *supra*, 11 Cal.3d at 514-15. Implicit in section 1094.5 is a requirement that the agency set forth findings to bridge the analytic gap between the raw evidence and ultimate decision or order. Topanga, 11 Cal.3d at 515.

The burden of proof falls upon the party attacking the administrative decision to demonstrate wherein the proceedings were unfair, in excess of jurisdiction or showed prejudicial abuse of discretion. Alford v. Pierno, (1972) 27 Cal.App.3d 682, 691. The standard of proof in the original administrative proceedings is irrelevant to this determination. The standard of proof on mandamus review of factual determinations of a tribunal is governed by the degree to which it is appropriate to presume correctness of such determinations. An independent judgment review carries a strong presumption that the agency's findings are correct (Ev. Code §664), and the party challenging such findings is required to "convince the court that the board's decision is contrary to the weight of the evidence," which means only that the evidence does not preponderate in favor of the agency's decision. Chamberlain v. Ventura County Civil Service Commission, (1977) 69 Cal.App.3d 362, 369, 370-71; Ettinger v. Board of Medical Quality Assurance, (1982) 135 Cal.App.3d 853, 856, 858.

The propriety of a penalty imposed by an administrative agency is a matter in the discretion of the agency, and its decision may not be disturbed unless there has been a manifest abuse of discretion. Lake v. Civil Service Commission, (1975) 47 Cal.App.3d 224, 228. In determining whether there has been an abuse of discretion, the court must examine the extent of the harm to the public service, the circumstances surrounding the misconduct, and the likelihood that such conduct will recur. Skelly v. State Personnel Board, (1975) 15 Cal.3d 194, 217-218. Neither an appellate court nor a trial court is free to substitute its discretion for that of the administrative agency concerning the degree of punishment imposed. Nightingale v. State Personnel Board, (1972) 7 Cal.3d 507, 515. The policy consideration underlying such allocation of authority is the expertise of the administrative agency in determining penalty questions. Cadilla v. Board of Medical Examiners, (1972) 26 Cal.App.3d 961.

B. Governing Law

Business & Professions ("B&P") Code section 822 provides:

"If a licensing agency determines that its licentiate's ability to practice his or her profession safely is impaired because the licentiate is mentally ill, or physically ill affecting competency, the licensing agency may take action by any one of the following methods:

(a) Revoking the licentiate's certificate or license.
(b) Suspending the licentiate's right to practice.
(c) Placing the licentiate on probation.
(d) Taking such other action in relation to the licentiate as the licensing agency in its discretion deems proper.

The licensing agency shall not reinstate a revoked or suspended certificate or license until it has received competent evidence of the absence or control of the condition which caused its action and until it is satisfied that with due regard for the public health and safety the person's right to practice his or her profession may be safely reinstated."

D. Statement of Facts.

1. Petitioner's Background

Petitioner Eisenkop is a gynecologic oncologist and surgeon, a field involving surgery and cancer chemotherapy. AR 466-67. After completing a residency in obstetrics and gynecology, he completed a fellowship in gynecologic oncology at UCLA in 1985. Id. He is board-certified in gynecologic oncology, has taught at the LAC/USC Medical Center and Stanford University, and is extensively published. AR 1098-1104. Eisenkop also reviews articles for various medical journals, most focusing on oncology and gynecology. AR 474.

In 1996, Petitioner developed throat cancer for which he was successfully treated with high-dose radiation chemotherapy. AR 474-75. He has been left with "no jaw muscles to speak of", can "only open [his] mouth one centimeter", has no sensation in his lower lip or jaw, cannot chew solid food, and cannot use a straw. AR 476. He has dry mouth (xerostomia) due to "essentially no saliva". To speak, he must have liquids "every ten seconds to every few minutes," depending on the situation. AR 476, 478. If required to speak on any sort of sustained basis, his speech typically becomes slurred, mumbled, and difficult to understand. AR 478-79. He also has high-frequency hearing loss from the chemotherapy and radiation which makes it hard to hear with any background noise. AR 477, 398-99.

Eisenkop's speaking difficulty can be temporarily relieved by resting his voice, allowing moisture from the air and lungs to moisten his mucous membranes. AR 400, 485-86. Due to his physical limitations, Eisenkop should work in quiet situations with a minimum of external noise. AR AR 487. This minimizes the strain on his voice in talking, enables him to hear better. AR 487. He also should work with staff he knows well in order to minimize the need for unnecessary talking and strain on his voice. Id. He has requested to work with the same staff during surgeries in order not to repeat himself and be understood by staff. AR 484, 490-91.

In 2008, Eisenkip began suffering from simple, partial motor seizures, meaning without a cognitive effect. AR 480-82. There were three or four episodes in ensuing months. AR 480-482. The seizures are treated with anticonvulsant medication. Id.

According to Dr. Harris Fisk, Petitioner's board-certified neurologist expert, the seizures are characteristic and repetitive. AR 301. The seizures do not produce confusion or have "zone episodes" -- meaning momentary detachment from one's environment -- and do not produce an after effect. AR 302.

2. Petitioner's Skill

Dr. Charles Kimelman, an ob/gyn in Tarzana, has worked with Eisenkop on many cases over the years, including at Cedars-Sinai Medical Center. AR 331-32, 335, 349-351. Eisenkop is easily the best gynecologic oncologist in Tarzana and has surgical results that are "the best in the world". AR 340. "[T]here is nobody in our community who responds as rapidly, not asking questions about a patient's insurance or anything else." Id.

Dr. Nicola Spirtos, a gynecologic oncologist, has known Eisenkop for many years. The specialty is highly specific involving complex gyn surgery and requires skills that other surgeons simply do not have. AR 446. There are only two to three other gynecologic oncologists in the San Fernando Valley. AR 460-61. Eisenkop's surgical results are much superior to those of the vast majority of his peer gynecologic oncologists. AR 459.

Dr. Louise Garcia, an obstetrician and gynecologist has known Eisenkop for twenty years. AR 717. She refers extremely complex surgical cases to him. AR 719.

Dr. Patrick J. Baggott, an obstetrician and gynecologist, submitted a declaration stating that Dr. Eisenkop is "an excellent surgeon who often handles the most difficult cases." AR 1171 (¶8). He is "the best surgeon I have ever worked with". Id., (¶3).

Similar accounts of Dr. Eisenkop's surgical skill were presented in declarations submitted by other physicians and nurses, including Dr. Roy Avalon, Dr. Hannah Grossman, Dr. Michael Eshaghian, and Registered Nurses Daryl Lemick and Brigitte Saylor. AR 1172-80.

3. The May 21, 2012 Incident

On May 21, 2012 from approximately 7:00 pm to 11:50pm., Eisenkop was involved in a surgery at St. Joseph's Medical Center in Burbank that proved difficult because of the patient's prior surgeries, significant scar tissue, and prior suture of th intestine to the abdominal wall. AR 53, 81, 406-09, 421. At about 10:24 p.m., Eisenkop stopped talking and became silent for several minutes. *See* AR 5, ¶14. The testimony conflicted on what happened.

Nurse Rhodes

Karen Rhodes ("Nurse Rhodes"), a nurse assisting with the procedure, testified that Eisenkop stopped working, and just stood there silent for about 10-15 minutes. AR 60. Rhodes was not specifically watching the clock at the time of the incident. AR 60. When he stopped working: "he stopped using instruments to manipulate the tissue." AR 46. He was standing in his normal posture mumbling like he was trying to communicate. AR 61. He stared blankly for a few moments. Id. The staff tried to see if he was all right, asking what he was saying and if they could get him a seat or some water. AR 60. He seemed not to be aware of his surroundings for 10 to 15 minutes, and slowly started to come out of it and started making sense and speaking coherently. AR 61.

Several hours into the surgery Eisenkop asked the anesthesiologist to insert a nasogastric ("NG") tube. AR 49. An NG tube had been inserted at the beginning of the procedure and Eisenkop previously had confirmed it to be in place. AR 49-50.

Eisenkop then asked Nurse Rhodes for his history and physical ("H&P") for the patient. When she provided him with Dr. Ahdoot's H&P -- the only H&P on file -- Eisenkop requested his own H&P for the patient. AR 48-49. She showed Eisenkop the H&P they had, apologizing

that they did not have his (Eisenkop's). She looked for one, and could not find it. AR 72-74, 83-84, 1359.

She never pressured Dr. Ahdoot to call Dr. Lin, also a gynecological oncologist, or tell Dr. Ahdoot that she was going to call a general surgeon unless he called Dr. Lin to assist. AR 59. She was very concerned when Eisenkop finished the surgery, but Dr. Ahdoot and Dr. Lin were present. AR 62. Immediately after the surgery, Nurse Rhodes asked Tech Ochoa to make written notes about the incident, which they agreed was bizaare. AR 79-80.

In an e-mail sent by Nurse Rhodes to her supervisor on May 22, 2012, she stated that "Dr. Eisenkop then asked several questions that showed he was not familiar with this patient as he had been at the start of surgery" and "demanded to see 'his' H&P for the patient." AR 1359. He did so even though Dr. Ahdoot was the primary physician for the patient. Id. Nurse Rhodes' email also stated: "He stopped surgery and asked anesthesia to insert an NG tube before the bowel was stapled for resecting, even though he had been there at the time out when he personally affirmed that anesthesia had put an NG tube in several hours prior." AR 1359.

Nurse Rhodes was not aware that the patient was also Eisenkop's patient, and acknowledged that on the at least half a dozen times she had worked with Eisenkop, he always asked to see his own history for patients. AR 51.

Tech Ochoa

Jorge Ochoa ("Tech Ochoa"), an assisting scrub technician, had worked with Eisenkop 50 times. AR 94. He testified that he is an experienced surgical technician who anticipates the surgeon's needs. AR 102-03. The surgical procedure of May 21, 2012 was an easy case despite the adhesions and compromise of the bowel. AR 127-28.

During the May 21 surgery, Eisenkop asked for an instrument which he (Tech Ochoa) offered, but Eisenkop did not take. AR 92. Eisenkop's demeanor changed and he kind of froze in place. AR 93. He stopped working. AR 112. He made an attempt to say something, which was mumbling. AR 93. The group could not understand, and the surgery came to a halt. Id. Dr. Ahdoot asked Eisenkop to step to the side and have a seat, and if he wanted something to drink. Id. Eisenkop made an attempt to communicate, but was not understandable. Id. Eisenkop's face was nonresponsive and he was dislocated from what was going on. AR 94. The silence lasted about 10-15 minutes. AR 93, 96. Dr. Ahdoot called in Dr. Lin. AR 95. When Eisenkop came around, he looked at Tech Ochoa with a stole look and said in a surprised tone: "what are we doing here?" AR 96. At that point, Eisenkop asked for a H&P for the patient. AR 97. Eisenkop said he wanted to close the abdomen without correcting the problem; he had no recollection of what had occurred previously. AR 119-20.

He was not present when Eisenkop closed the abdomen because of the shift change. AR 119-20. As he stepped out of the room, Nurse Ochoa asked him to write down what he had seen, which he did. AR 118-19.

Dr. Ahdoot

The other surgeon present, Dr. David Ahdoot, testified that he has worked with Eisenkop on a regular basis, more than one case a week, since 1999 or 2000. AR 412. The surgery in question started at 7 p.m. and proved very difficult. AR 410, 421. This was one of the most

difficult cases I've ever done". AR 421. The reason for the difficulty is that three hours into surgery they discovered multiple permanent sutures in the bowel from a prior tummy-tuck, requiring a bowel resection and had to open her up and switch to laparotomy. AR 410. There was talking, tension in the room, and chaos in doing an open surgery instead of laparscopic surgery. AR 411.

Eisenkop appeared to be frustrated around the time they opened the abdomen. AR 423. He became uncommunicative and stopped operating, but never stepped away from the operating table. AR 429. Someone did ask him if he wanted juice. AR 422. When Eisenkop became uncommunicative, Dr. Ahdoot recommended they stop and wait for the shift change, which was noisy, to end. AR 428, 430, 435. Dr. Ahdoot asked Eisenkop how he was doing. AR 435. He did not respond, but continued to operate. AR 435-36. There was a time when Eisenkop was standing still and not operating. AR 436.[1]

Staff (Nurse Rhodes and Tech Ochoa) were asking for a general surgeon to come in. AR 413-14. Dr. Ahdoot felt pressure to call in Dr. Lin, and did so because Dr. Lin "was a better assistant to Dr. Eisenkop than myself" for the bowel resection. AR 413.[2] When Dr. Lin came in, he did not take over the surgery. Eisenkop remained the primary surgeon and both Drs. Ahdoot and Lin assisted. AR 420.

From his experience with Eisenkop, the latter reviews his H&P on a patient before he finishes the procedure to make sure he did exactly what he told the patient he was going to do. AR 415-16.[3]

Dr. Ahdoot referred to Nurse Rhodes' criticism about the NG tube as "petty" and "very disrespectful and inappropriate" because in a long surgery you want to double and triple check

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[1]Dr. Ahdoot submitted a declaration that also states that Eisenkop stopped verbally communicating. "At certain points he was asked questions by staff and he did not respond. However, Dr. Eisenkop did not stop operating. Nor did he step away from the patient. He did not put down his surgical instrument. He appeared to be continuing working but was not responding to some questions the staff had." AR 1160-61 (¶6).

[2]Dr. Ahdoot's declaration also states that a nurse asked for a general surgeon. AR 1161 (¶7) ("[O]ne of the nurses [said] I believe the general surgeon is still in the hospital, should we call him"). The only nurse present was Nurse Rhodes. AR 78-79.

[3]Dr. Ahdoot's declaration also states that Eisenkop routinely asks to see his own H&P after surgery, which can irritate nurses and scrub techs, but "it is better practice to ask to review it." AR 1161-62 (¶11). Other witnesses confirmed that Dr. Eisenkop's custom to ask to review his own H&P after surgical procedures. AR 252-53 (Dorothy Swanson, a registered nurse first assistant ("RNFA") who worked with Eisenkop weekly over multiple years); AR 703 (Brigitte Saylor, a RNFA who worked with Eisenkop over the years said Eisenkop likes to review his H&P "before he starts the case"); and AR 722 (Dr. Louise Garcia, one of Eisenkop's colleagues "had seen him do that a couple of times").

that everything is ok. AR 425.[4]

Eisenkop

Eisenkop testified that he was "resting his voice" during the surgery. AR 505. His jaw was sore, his speech was slurred, and he did not think talking was necessary. AR 505-06. While he was resting his voice, the staff was asking if he was all right. He said "yeah, I'm resting my voice," but his voice was slurred and they could have heard only mumbling. AR 506-07. There was a point where they were asking questions to check on him, and he did not respond. AR 507. He was frustrated and just stopped performing the surgery during the shift change. AR 508. He just stood by the patient and waited for them. AR 509. When Dr. Lin arrived, he thought it was unnecessary. However, given the hostility, negativity, and the fact that his mouth was dry, he did not object. AR 510.

Dr. Paramesh

The Board's expert, Dr. Paramesh, is board-certified in neurology. AR 149. He performed a neurological exam of Eisenkop and reviewed his medical records. AR 151-52. He opined that Eisenkop possibly suffered a "simple partial psychic seizure" on May 21, 2012, which he referred to as involving "confusion, garbled speech, memory loss, difficulty in finding words, and basically not fully aware of what your conscious state is." AR 176, 179-80, 198.[5] He recommended that Eisenkop continue his medication, repeat an EEG at least twice a year, and repeat an MRI scan, and restrict his work schedule. AR 153-54. Lack of sleep and too much work can precipitate a seizure. AR 154.

Dr. Fink

Dr. Harris Fink, Eisenkop's board-certified neurology expert, opined that a simple partial motor seizure occurred which caused Eisenkop to lose the ability to speak for several minutes, with no sensory or cognitive impairment of any kind. AR 302. He is not significantly impaired by seizures in the current circumstances, but "anything could happen to anyone at any time." AR 314.

4. The May 31, 2012 Interview

After Rhodes reported the incident of May 21, 2012, the management of St. Joseph Medical Center ("St. Joseph") placed Eisenkop on summary suspension and required that he obtain medical clearance.

On May 31, 2012, Petitioner was interviewed by St. Joseph's Medical Executive Committee ("MEC"). *See* AR 9, ¶25. Eisenkop had only slept two or three hours the previous

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[4]RNFA Swanson testified that Eisenkop routinely checks to confirm that the NG tube is in place, to protect the safety and comfort of the patient. AR 253-54.

[5]Dr. Paramesh's report inconsistently states that "Dr. Lin...supposedly completed the procedure, although Dr. Eisenkop feels he was fully in control, and he completed the procedure himself." AR 1080.

night, was under stress, and was nervous. AR 201, 298. The interview was recorded without Eisenkop's knowledge. AR 526. There was a period of several minutes during the interview in which Petitioner gave non-responsive answers to questions. AR 531. He had a negative history with the MEC and did his best. AR 639. Nonetheless, Eisenkop was not coherent in his responses. AR 301. AR 9-12, #26.

Dr. Jacks

Petitioner's expert psychiatrist, Dr. Brian Jacks, testified that Eisenkop's responses were understandable in light of the stress and anxiety he felt. Eisenkop felt compelled to say something rather than staying silent in order to assure the interviewers that no seizure was being experienced. He was deliberately evasive due to his tiredness and the stressfulness of the situation, to gain time to carefully consider his responses and answer in a non-confrontational way as instructed by his attorney. AR 361, 376-77. Eisenkop never had a complex partial seizure before, and the lack of such history made it less likely that he suffered cognitive difficulty on May 31.

Dr. Paramesh

Dr. Paramesh found the May 31 episode suspicious of seizure, but could not opine whether it was simple or complex.

Dr. Fisk

Dr. Fisk acknowledged the possibility of a seizure, but opined that it was more likely stress-related confusion because Eisenkop's answers were being challenged. (The ALJ disagreed, stating that the transcript reflects no challenge to Eisenkop's answers.)[6]

Dr. Kowell

Dr. Arthur Kowell, Petitioner's treating neurologist, testified that Eisenkop's nonresponsive answers on May 31 were indicative of extreme sleep deprivation and anxiety rather than a complex partial seizure. AR 557. The difference between a simple partial seizure and a complex one is that the latter involves a loss of consciousness or awareness that does not exist for a simple partial seizure. AR 448. A simple partial seizure is pretty stereotyped. AR 559.

5. The Sutherling EEG

Prividence Tarzana Medical Center ("Tarzana") also summarily suspended Eisenkop's privileges and referred Eisenkop to Dr. Donald Sutherling for evaluation.

Dr. Sutherling performed a number of EEGs on Eisenkop.[7] Dr. Sutherling's June 11, 2012 EEG was abnormal, showing multiple temporal spikes. AR 888. Dr. Sutherling interpreted

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[6]Neither party cited the evidence on this testimony, only the ALJ's findings which are not evidence of the underlying facts.

[7]Dr. Sutherling did not testify.

these spikes as a partial seizure disorder. Id. A later EEG on July 17, 2012 showed the same kinds of spikes, resulting in a modification of Eisenkop's medication. The report for the July 17, 2012 EEG was abnormal, showing multiple bilateral temporal spikes showing a partial seizure during sleep which awakened Eisenkop. He was not confused upon awakening. AR 883. Dr. Sutherling interpreted those spikes as a partial seizure disorder. Id. The August 21, 2012 EEG showed improvement. AR 879.

Dr. Kowell, Eisenkop's treating neurologist, opined that Eisenkop had a simple partial seizure when he was being monitored by Dr. Sutherling. AR 559.

Petitioner's expert neurologist, Dr. Lorne Label (AR 267, 269) testified that Dr. Sutherling, who has the strongest epilepsy credentials, could not be sure if Eisenkop suffered a seizure during the May 31 interview or was just reacting poorly due to stress, fatigue, and anxiety. AR 297.

Dr. Label also testified that Eisenkop's history of chemotherapy and radiation treatment will cause some abnormalities on his EEG. AR 274. Dr. Sutherling's June 11, 2012 EEG shows an abnormal spike on the left front of the temporal lobe. AR 275. The spike indicates the possibility of a seizure. AR 310. It also is something one would see in a seizure disorder, but does not by itself indicate a clinically manifested seizure. AR 276. The June 11 results do suggest that Eisenkop should be treated with anti-convulsant medication. AR 277, 310. The July 11 results also show that "this is someone who needs to be on anticonvulsant medication, but nothing more than that." AR 279.

7. The Tarzana Agreement

To regain his privileges at Tarzana, on November 11, 2012 Eisenkop signed an agreement that he would use an assistant surgeon in all laparotomy and laparoscopic procedures. AR 873 (¶7). The agreement also limits Eisenkop's office and surgery hours to 50 hours per week. AR 873 (¶4). The agreement also stated: "I agree that the restrictions and monitoring described in this letter are reasonable and warranted and that I will comply with each of the requirements." AR 874.

Eisenkop testified that he had no privileges at Tarzana from June 2012 until January 2013, which was 40% of his practice. AR 539, 542. During this period, he was seeing patients at other hospitals. Id. He agreed to comply with the agreement's terms, but did not believe they were reasonable. AR 541.

8. The ALJ's Decision

The ALJ found that the Board did not have to prove that Eisenkop experienced seizures on May 21 and 31, 2012. The Board need only prove that his ability to practice safely is impaired due to physical illness affecting his competency under B&P Code section 822. AR 19, ¶5. The Board met this burden because Eisenkop experienced two unusual occurrences in May 2012. AR 20, ¶'s 6-9.

The ALJ recommended revocation of Eisenkop's license, a stay of revocation, and placement on probation for ten years under various conditions. AR 23. One condition is that an assistant surgeon must be present for the duration of each surgical procedure that Dr. Eisenkop performs. AR 23, ¶16; AR 26, ¶4. A RNFA may not be used in place of an assistant surgeon. Id.

Another condition is that Eisenkop must limit his work to periods of no more than ten consecutive hours. AR 25, ¶24.

The Board accepted the ALJ's recommendation with only a typographical correction. AR 1.

D. Analysis

Petitioner Eisenkop argues that the ALJ[1] abused his discretion in finding that he suffered seizures on May 21 and May 31, 2012 for the following reasons: (1) the ALJ should not have not credited the testimony of Nurse Rhodes and Tech Ochoa over the testimony of Eisenkop and Dr. Ahdoot; and (2) the ALJ should have credited Eisenkop's experts more than the Board's expert opinions.

As a threshold matter, the parties agree that Eisenkop has a seizure disorder manifested by an inability to speak. The ALJ did not find that Petitioner suffered from seizures on those May 21 and 31. Rather, the ALJ found that Eisenkop "experienced two unusual occurrences." AR 20.

1. May 21, 2012

Petitioner argues that the ALJ wrongly credited the testimony of Nurse Rhodes and Tech Ochoa. He argues that his silence during the surgical procedure lasted only three to four minutes, as testified to by him, and not ten to 15 minutes, as Nurse Rhodes and Tech Ochoa testified. He argues that there is reason to doubt Nurse Rhodes and Tech Ochoa, and Dr. Ahdoot, the "only independent witness," corroborated Eisenkop that he was simply resting his voice for about three to four minutes.

Petitioner provides no reason why Nurse Rhodes and Tech Ochoa would testify falsely that for ten to 15 minutes Eisenkop stopped performing surgery and just stared blankly ahead unaware of his surroundings, slowly starting to come out of it make sense at the end of the period. Both had worked with Eisenkop before and Petitioner adduced no motive for them to lie.

Petitioner attacks Nurse Rhodes' credibility by pointing out that she asked Tech Ochoa to make notes immediately after the incident (Mot. at 5), but this is what any reasonable health care provider should do after a bizarre incident.

Petitioner contends Nurse Rhodes was vindictive by requesting his own H&P when she gave him Dr. Ahdoot's H&P. Id. However, Nurse Rhodes explained that she thought Dr. Ahdoot was the primary physician for the patient, and acknowledged that he always asked to see his own history for his patient on the at least half a dozen times she had worked with him. There is no evidence whatsoever that she was irritated by Eisenkop's request for his own H&P.

Petitioner calls Nurse Rhodes' criticism of Eisenkop's inquiry about an NG tube inserted hours earlier, and Dr. Adhoot called such criticism "petty." Mot. at 6. But Petitioner mischaracterizes Nurse Rhodes' testimony about the NG tube. According to her, Eisenkop did not merely check to confirm that the NG tube was in place; several hours into the surgery he asked the anesthesiologist to insert a NG tube even though one was in place. This reflects a lack of awareness as to what was going on.

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[1]For clarity, the court will refer to the ALJ's proposed decision, not the Board's decision.

Petitioner's only criticism of Tech Ochoa is that he referred to the procedure as an easy case, whereas Dr. Ahdoot testified that it was one of the most difficult cases he had ever done. Mot. at 7. Of course, each health care provider performs a different role, and the level of difficulty depends on the role performed. A procedure that is easy for a technician may be difficult for a doctor because of their different tasks, and Tech Ochoa may not have appreciated how difficult the surgery was. Additionally, Tech Ochoa was not present for the entire surgery. While the court assumes that he erred in characterizing the surgery as easy, this error reflects only on his judgment, not his ability to perceive events. As such, it bears little on his credibility in testifying to his observations on May 22.

In contrast, Dr. Ahdoot appeared reluctant to admit anything that could adversely impact his colleague with whom he has worked regularly for more than 15 years. It was Dr. Ahdoot who lacked credibility, not Nurse Rhodes or Tech Ochoa. Yet, even Dr. Ahdoot had to admit that Eisenkop became uncommunicative and stopped operating. Someone did ask him if he wanted juice, and Dr. Ahdoot recommended they stop and wait for the shift change to end. Obviously, something was wrong and Eisenkop was not merely resting his voice. When Dr. Ahdoot asked Eisenkop how he was doing, he did not respond. Dr. Ahdoot also admitted that he called in Dr. Lin after he was pressured to do so by staff. He said he did so because Dr. Lin "was a better assistant to Dr. Eisenkop than myself" for the bowel resection, but this explanation rings untrue. Would not Eisenkop be the better judge of whether some other surgeon should be brought in? Why did he not do it if Dr. Lin would be a better aide? The truth is that Dr. Ahdoot brought in Dr. Lin because he was concerned – like Nurse Rhodes and Tech Ochoa – that Eisenkop was not competent to perform the remaining surgery.

In light of these facts, Eisenkop's explanation that he merely was resting his voice to allow moisture to build up simply is untrue.[9]

2. May 31, 2012

On May 31, 2012, Eisenkop was interviewed by St. Joseph's MEC. It is undisputed that there for several minutes during the interview his answers to the questions were non-responsive. *See* AR 9-12 (¶26).

Eisenkop explained his failure by telling Drs. Paramesh and Jacks that had only slept two or three hours the night before the interview. He contended that had been under great stress the previous ten days as a result of the impending hearing and need to obtain medical clearance, which had also adversely impacted his sleep for the prior ten days. Petitioner also argues now that in the past he had never experienced a seizure in which -- instead of losing his ability to speak -- he retained that ability but not the ability to understand and/or properly answer. Mot. at 13.

The ALJ did not determine that Eisenkop suffered a seizure at the interview. Instead, the ALJ characterized the incident as an "unusual occurrence." AR 20 (¶6). He did not accept the

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[9]The court need not address the ALJ's reasons why Eisenkop's testimony was embellished and not credible (AR 8 (¶22)), or his arguments against that finding (Mot. at 11-12), except to note that Eisenkop could have answered the staffs' questions by using his hands if his neck range of motion was too limited to nod his head.

explanation of Eisenkop's experts that the occurrence was the result of stress, nervousness, and fatigue. The ALJ noted that Petitioner had no history of any such condition, and no difficulty testifying at the stressful administrative hearing. Noteworthy was the fact that Petitioner started the May 31 interview properly, and suddenly became confused and non-responsive well into it. Id. (¶8).

3. Characterization of the Two Episodes as Seizures

The Board's expert, Dr. Paramesh, performed a neurological exam of Eisenkop, reviewed his medical records, and opined that on May 21 Eisenkop possibly suffered a "simple partial psychic seizure" involving "confusion, garbled speech, memory loss, difficulty in finding words, and basically not fully aware of what your conscious state is." AR 176, 179-80, 198. Lack of sleep and too much work can precipitate a seizure. AR 154. Dr. Paramesh found the May 31 episode suspicious of seizure, but could not opine whether it was simple or complex.

Petitioner's expert neurologist, Dr. Fink, opined that a simple partial motor seizure occurred which caused Eisenkop to lose the ability to speak for several minutes, with no sensory or cognitive impairment of any kind. AR 302.

Petitioner argues that Dr. Paramesh's opinion was much less credible that the opinions of his experts because Dr. Paramesh's examination of Eisenkop was "quite minimal," and Eisenkop's documented seizures in 2008 did not involve cognitive dysfunction – only an inability to speak. Mot. at 8.

Petitioner cites to no evidence showing that Dr. Paramesh's examination was minimal. Dr. Paramesh's opinion that on May 21 Eisenkop suffered a psychic seizure, which affects mental state, is supported by the facts as relayed by Nurse Rhodes and Tech Ochoa. Only by crediting Eisenkop's testimony can one reach the conclusion that the seizure was motor in nature and not psychic. While Petitioner he had never previously suffered a psychic seizure, there was no medical opinion offered that his seizure disorder could not progress to that type of seizure. In any event, the experts agreed that Petitioner suffered some type of seizure on May 21.

Dr. Fisk acknowledged the possibility of a seizure on May 31, but opined that it was more likely stress-related confusion because Eisenkop's answers were being challenged. Petitioner's expert psychiatrist, Dr. Jacks, testified that Eisenkop's May 31 responses were understandable in light of the stress and anxiety he felt. According to Dr. Jacks, Eisenkop felt compelled to say something rather than staying silent in order to assure the interviewers that no seizure was being experienced. He was trying Due to his tiredness and the stressfulness of the situation, he was trying to gain time to carefully consider his responses and answer in a non-confrontational way as instructed by his attorney. Dr. Kowell, Petitioner's treating neurologist, also testified that Eisenkop's nonresponsive answers on May 31 were indicative of extreme sleep deprivation and anxiety rather than a complex partial seizure.

It seems likely that Petitioner suffered a seizure on May 31. The ALJ properly discounted Dr. Fisk's opinion – that Eisenkop suffered from stress-related confusion because his answers were being challenged -- as unsupported by the transcript. AR 17 (¶38). The ALJ also discounted the opinions of Drs. Fisk, Jacks, and Kowell that stress and fatigue were the likely cause of his non-responsiveness on the well supported ground that they do not explain why Eisenkop was able to respond at the outset of the interview when his stress and anxiety levels

were highest, and only suddenly became non-responsive mid-interview. AR 18 (¶41).

Nonetheless, Petitioner's expert neurologist, Dr. Lorne Label, testified that Dr. Sutherling had the strongest epilepsy credentials, and the latter could not be sure if Eisenkop suffered a seizure during the May 31 interview or was just reacting poorly due to stress, fatigue, and anxiety. Thus, a conservative conclusion is that Eisenkop probably suffered a seizure on May 31, but not necessarily so.

The existence of seizure activity in May is corroborated by Dr. Sutherling's EEGs on Dr. Sutherling's June 11 and July 17 EEGs showing abnormal multiple temporal spikes that Dr. Sutherling interpreted showing as a partial seizure disorder. Id. Even Dr. Kowell, Eisenkop's treating neurologist, opined that Eisenkop had a simple partial seizure when he was being monitored by Dr. Sutherling. AR 559.

Thus, Eisenkop suffered at least two seizures between May and July 2012, one of which occurred in the operating room. The weight of the evidence supports the ALJ's conclusion that Eisenkop's seizure disorder is a physical illness affecting his competency under B&P section 822. Therefore, cause existed to revoke his license and place him on probation.

4. The Probation Conditions

The ALJ found that the experts agreed that the risk of seizure can be minimized by maintaining an appropriate medication regimen and getting adequate rest. However, Eisenkop prides himself on his work ethic, takes as many referrals as he can, is strong willed, and was somewhat defiant about Tarzana's rest requirement. AR 21-22 (¶'s 12-13). Therefore, the Board cannot count on him to ensure that he gets adequate rest. Id. To ensure patient safety, an assistant surgeon capable of assuming his duties also must be present for the duration of each surgical procedure. AR 23 (¶16). Therefore, non-standard terms of probation must be imposed for continued medical evaluation and treatment, blood testing, limitation of work hours, and use of an assistant in all procedures. AR 23 (¶18).

The ALJ imposed ten years of probation during which Petitioner must, *inter alia*, (1) be accompanied by an assistant surgeon during all surgical procedures who could take over the surgery, and (2) limit his work-related hours to periods of no more than ten consecutive hours. Work-related hours are defined as including time spent between a surgery's scheduled and actual start and travel time. AR 25-26 (¶3-4).

Petitioner argues that the Board never asked for an assistant surgeon to be present during Eisenkop's surgery, even when it sought an interim suspension order. Petitioner never had the opportunity to address this condition, the only possible source of which is the Tarzana agreement containing the same term. No witness testified to the significance or need for such a term. Eisenkop routinely uses RNFAs, who are eminently qualified to assist. An assistant surgeon (who would be an ob/gyn and not a gynecologic oncologist) would do exactly what a RNFA would do if Eisenkop suffered a seizure during an operation; he or she would close the wound and terminate the surgery. The assistant surgeon would not be qualified to do more. AR 1169.

In opposition, the Board relies on the need to protect the public, and notes that in closing argument (AR 763) the Board's counsel described the Tarzana agreement as a "model" for probation conditions. A second surgeon "would be certainly be of use should petitioner suffer a seizure in surgery." Opp. at 6.

The Board's position that an assistant surgeon would be helpful is not good enough. The requirement of an assistant surgeon is a non-standard condition of probation. Petitioner never had an opportunity to contest this condition, and the only evidence is that an assistant surgeon would do no more than a RNFA. As an offer of proof as to what evidence he would present if given the opportunity, Petitioner submitted a declaration in connection with his motion to stay in which he explained that he routinely works with RFNAs, these persons are accustomed to assisting him which limits the amount of painful talking he must do, he is required to talk much more with an assistant surgeon, and it has been difficult for him to find assistant surgeons for his cases at Tarzana. Reply at 6 (quoting July 18, 2014 Eisenkop declaration from motion to stay). Imposition of this condition was arbitrary, and remand is required for the Board either to delete this condition or give Eisenkop an opportunity to contest it.

With respect to the time limitation, the experts agree that Eisenkop needs adequate rest to avoid the risk of seizure. Petitioner acknowledges the importance of sufficient rest, but contends that the definition of "10 consecutive hours" as including driving time and time between the scheduled start of a surgery and the actual start time is too draconian. Petitioner argues that the undisputed evidence is that he needs an average of seven to eight hours of sleep to be adequately rested. The surgeon must arrive exactly on time (AR 493), but there often are long delays between a surgery's scheduled start and its actual start, and the downtime between surgeries can be anywhere from 20-52% of the time. AR 675. Petitioner contends that the condition be modified to provide for a minimum of seven hours of sleep per night, or else that the consecutive hour limitation be increased to 14 hours per day. Mot. at 15.

The Board defends this condition solely on the ground that Petitioner's argument strays into the Board's discretion. Opp. at 6.

The work hour limitation appears to come from Dr. Sutherling's letter, which suggests a 50-hour week if there were no other surgeons for the case, and a 60-hour week if there were. AR 1014. The Tarzana agreement also limits Eisenkop's total office and surgery hours to 50 hours per week. AR 873. The limitation to 10-consecutive work-related hours is supported by the evidence.

The court also sees nothing conceptually wrong with including drive time and downtime at the hospital within the definition of work-related hours if that also is supported by evidence. Whether the definition is appropriate depends on the stressors of driving and downtime in the hospital, and whether they could contribute to the onset of his seizures. It also depends on whether Eisenkop could reasonably monitor his downtime in calculating the ten-hour limit. Again, Petitioner was given no opportunity to contest the definition of work-related hours as including drive time and down time. The matter must be remanded to give Eisenkop an opportunity to contest the definition of work-related hours.

E. Conclusion

The Petition for Writ of Mandate is denied in part and granted in part. Eisenkop will remain on probation, but the Petition is granted to the extent that the Board must exercise its discretion to either delete or modify the conditions requiring that an assistant surgeon be present during all surgeries and the definition of work-related hours, or else hold a further evidentiary hearing concerning these issues. The court will set a date for the return after remand at the

hearing.

Petitioner's counsel is ordered to prepare a proposed judgment and writ of mandate, serve them on the Board's counsel for approval as to form, wait 10 days after service for any objections, meet and confer if there are objections, and then submit the proposed judgment and writ along with a declaration stating the existence/non-existence of any unresolved objections. An OSC re: judgment is set for May 14, 2015 at 9:30 a.m.

04/28/2015

KAMALA D. HARRIS
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
JOHN E. RITTMAYER
Deputy Attorney General
State Bar No. 67291
California Department of Justice
300 South Spring Street, Suite 1702
Los Angeles, California 90013
Telephone: (213) 897-7485
Facsimile: (213) 897-9395
Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO MAY 22, 2013
BY: ANALYST

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: SCOTT EISENKOP, M.D. 4835 Van Nuys Boulevard, Suite 208 Sherman Oaks, California 91403 Physician's and Surgeon's Certificate Number G 41053, Respondent.	Case No. 17-2012-224090 **ACCUSATION**

Complainant alleges:

PARTIES

1. Complainant Linda K. Whitney brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about October 15, 1979, the Board issued Physician's and Surgeon's Certificate Number G 41053 to respondent Scott Eisenkop, M.D. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2015, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2004 of the Code states in part:

"The board shall have the responsibility for the following:

". . .

"(h) Issuing licenses and certificates under the board's jurisdiction."

". . ."

5. Code section 822 states:

"If a licensing agency determines that its licentiate's ability to practice his or her profession safely is impaired because the licentiate is mentally ill, or physically ill affecting competency, the licensing agency may take action by any one of the following methods:

"(a) Revoking the licentiate's certificate or license.

"(b) Suspending the licentiate's right to practice.

"(c) Placing the licentiate on probation.

"(d) Taking such other action in relation to the licentiate as the licensing agency in its discretion deems proper.

"The licensing section shall not reinstate a revoked or suspended certificate or license until it has received competent evidence of the absence or control of the condition which caused its action and until it is satisfied that with due regard for the public health and safety the person's right to practice his or her profession may be safely reinstated."

CAUSE OF ACTION

(Physical Illness Affecting Competency)

6. Respondent is subject to action under Section 822 in that he cannot safely practice medicine due to a physical illness affecting competency. The circumstances are as follows:

7. On or about May 21, 2012, respondent was doing a prolonged surgical procedure late in the evening. During the course of the surgery he paused and mumbled a few words that no one in the room could understand. According to multiple witnesses, multiple attempts were made by various persons in the room such as his assistant surgeon, anesthesiologist, scrub tech, as well as nurses to speak to him. One witness found him to be "confused, incoherent [and] disoriented" and unable to express himself. His assistant surgeon then asked him if he wanted to sit down or

have a glass of water, to which he either did not respond, or, according to respondent, could not hear, as there was "ambient noise." All of this lasted from five to ten minutes starting from the moment respondent made an incision in the patient's abdomen to correct an unanticipated complication of her bowel. In the meantime another surgeon was called to complete the procedure. Members of the surgical team observed respondent to be confused about significant details about the procedure.

8. On or about May 31, 2012, respondent attended a meeting of the Medical Executive Committee of Providence St. Joseph's Medical Center concerning the incident described in the preceding paragraph. During the course of the discussion, respondent once again lapsed into a period where he repeated himself, seemed confused, did not answer questions and kept saying "I'm tired." This lasted several minutes and respondent was mildly befuddled and confused thereafter. According to the respondent, he was sleep-deprived (only three or four hours of sleep) because he had to have multiple tests as a result of the May 21, 2012 incident described above, in addition to his regular schedule of work and hence was under a lot of duress and stress.

9. Respondent has privileges at Tarzana Medical Center at whose request an independent neurologist did an extensive evaluation of respondent, including three video electroencephalograph (EEG) examinations. The neurologist noted a history of partial seizures, that respondent takes an anti-seizure medication, exhibited a simple partial seizure during sleep in the course of one of the EEGs and concluded that respondent is at risk for seizures under conditions of sleep deprivation or high stress. He recommended that respondent continue the anti-seizure medication, avoid sleep deprivation and fatigue, have a shorter workweek of 40 hours to no more than a maximum of 50 hours and do not operate at odd hours past 5:00 or 6:00 p.m. to eliminate fatigue factors.

10. Respondent agreed to an examination by a physician chosen by the Board. On or about February 5, 2013, a neurologist carried out that examination. The neurologist concluded that respondent has a form of seizures called partial seizures and that respondent has had both simple (without loss of consciousness) and complex (with altered level of consciousness) partial seizures. They are presently controlled with adequate medication and, presumably, by the

changed schedule of practice that preceded respondent's third EEG. The Board-appointed neurologist also concluded that respondent must moderate his schedule in line with that recommended by the Tarzana Medical Center-appointed neurologist, in order to safely practice medicine.

PRAYER

WHEREFORE, complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 41053, issued to Scott Eisenkop, M.D.

2. Revoking, suspending or denying approval of his authority to supervise physician assistants, pursuant to Section 3527 of the Code;

3. Ordering him, if placed on probation, to pay the Medical Board of California the costs of probation monitoring;

4. Taking such other and further action as deemed necessary and proper.

DATED: May 22, 2013

LINDA K. WHITNEY
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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